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*Diamond, O. K.: New York J. Med. 59:1792, 1959.

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Mental Hospitals

Hospital Journal of the

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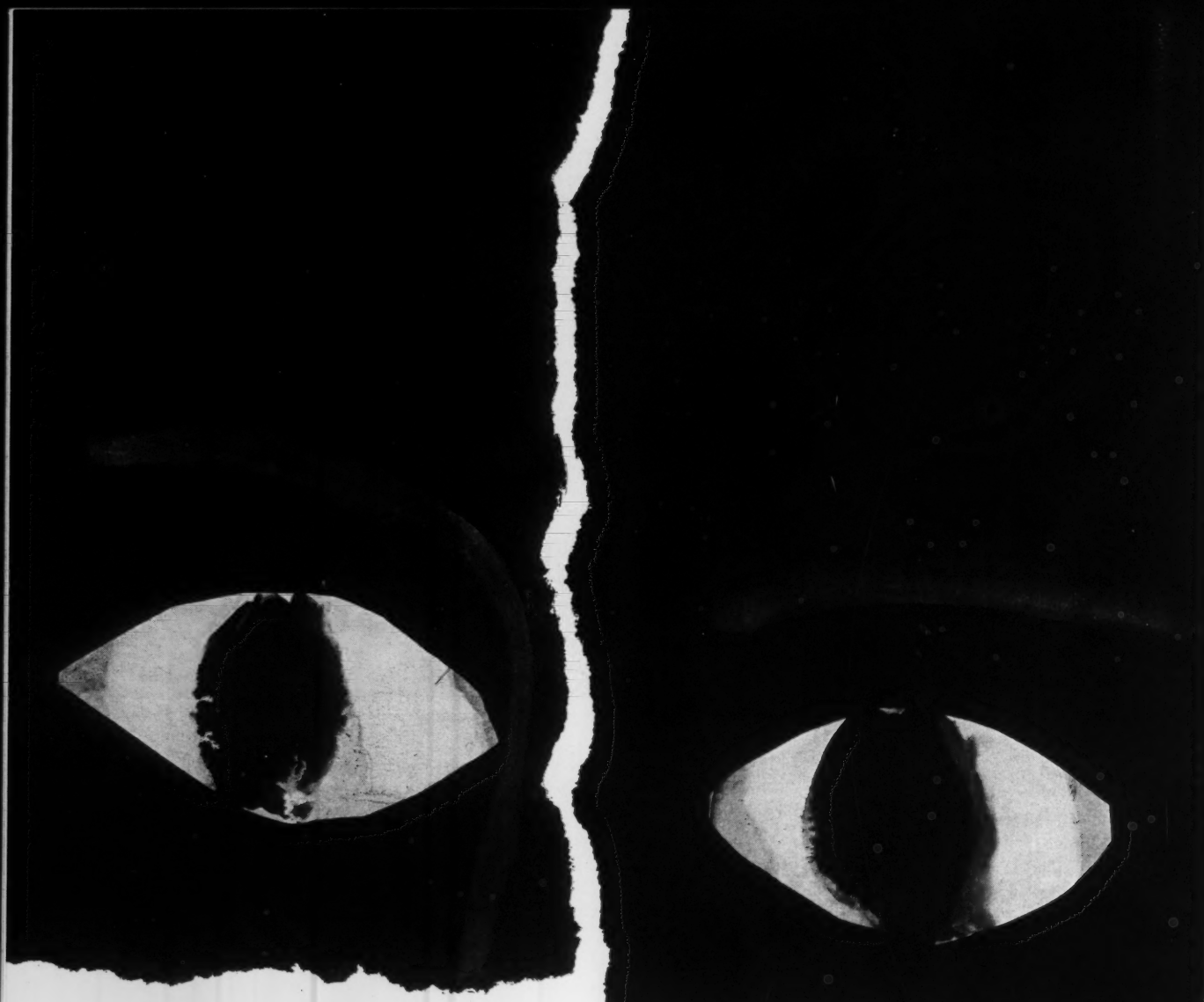
MENTAL HOSPITALS offers a forum for free discussion about matters of interest to persons involved in the care and treatment of psychiatric patients. Opinions expressed by the authors are theirs and do not necessarily represent the official policy of the American Psychiatric Association.



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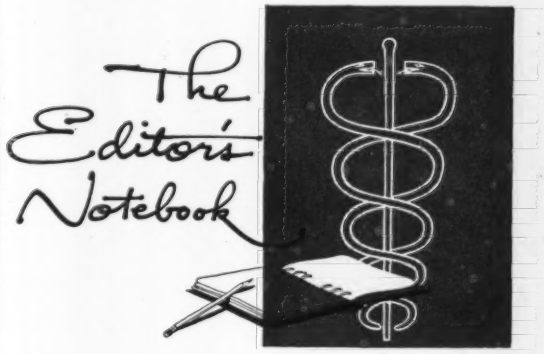

WE ARE ALL ENGULFED in the sweep of community psychiatry. As a profession, we are engaged in the mammoth task of changing our public image. Much will depend, no doubt, on how effectively American medicine—of which we are a part—comes to grips with the over-all national health problem. This is peripheral, however, to our own immediate concern of gaining community cooperation by presenting the truest possible likeness of psychiatry to public scrutiny.

This major concern occasionally gets buried under the very special problems faced by each segment of our profession—public and private hospital superintendents, psychoanalysts, biological psychiatrists, commissioners of mental health, professors of psychiatry, and others. But the success that any of these specialists will have in solving their own problems will be in direct proportion to the success achieved by our medical specialty as a whole in conquering the problem we share in common.

World War II launched psychiatry into the vast enterprise of allying itself more closely with the rest of medicine and with the community. All of us must contribute to this enterprise, but its most logical headquarters is the mental hospital, whether public or private; the hospital is the "showcase" for the multiple aspects of psychiatry and the diversified talents of everyone in this field.

We have already done much to change the image of our specialty, our practitioners, our hospital personnel, and our patients. We have reached the point where we not only call on citizens to support better psychiatric treatment, training, and research; we also ask them to share our therapeutic goals. This is implicit when we urge employers to hire former mental patients; when we call on the family physician to deal more competently with psychiatric aspects of his patients' complaints; when we enlist the help of policemen, ministers, teachers, public health nurses; when we encourage the medical community to open up its general hospitals to our patients; when we organize volunteer programs; when we propose day and night hospitals and half-way houses which allow patients to reside and function in the community; when we establish open hospitals and therapeutic communities.

These practices are familiar to many hospital staffs; a number of them were born in the vision and foresight of certain hospital administrators. But they can and must be applied on a larger scale. In the process of this application everyone working in either private or tax-supported hospitals must constantly remember our purpose—to change psychiatry's image in the public mind.

If the public mental hospital has to erase its image as an isolated place for the custodial care of incurables, the private hospital has to erase its image as an isolated rest haven for millionaires. Both must replace the prevailing image of mental patients—violent, immoral, and dangerous—with a more realistic picture. As we know, the average mental patient is more like other people than he is unlike them. This is a fact of life that, in the interest of public enlightenment, cannot be stressed too often.

In order to accomplish the change from caricature to reasonable facsimile, however, we must give as much as we receive. Mental hospitals, if they are to obtain the support they need, must find means to meet community needs and to inform the public that they are able and willing to do so. They must become a more intimate part of community health services; develop training courses for local general practitioners; collaborate whenever possible with school systems and universities to improve training and treatment methods; and disseminate information by providing able lecturers for outside groups, and by encouraging the visits of capable journalists.

The possibilities are endless, even for those mental institutions somewhat handicapped by their isolated locations. We cannot despair of bridging the distance to the nearest community when swift transportation facilities and mass communications media abound, and when—most important of all—the public is expressing a desire to help and be helped in achieving better mental health for everyone. Our image *can* change if only each hospital will take the initiative for doing its part in its own community.

Matthew Ross, M.D.

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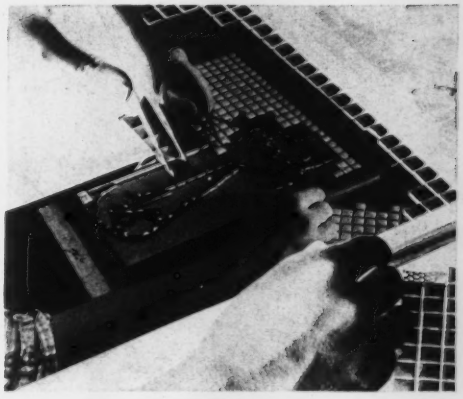

By C. GORDON EDGREN, M.D.
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The Institute of Living, Hartford, Connecticut

THE INSTITUTE OF LIVING owes its existence to Dr. Eli Todd, a man whose concepts were remarkably ahead of his time, and one who labored tirelessly on behalf of the mentally ill. In 1820 Dr. Todd spoke to a meeting of the Hartford (Connecticut) Medical Society. "The people of New England," he began, "inherit the constitution of their ancestors and partake to a greater or lesser extent of their hereditary disorders. One of these, and by no means the least considerable, is insanity."

He pointed out that only three public insane asylums then existed in the United States. "These are in Massachusetts, New York, and Pennsylvania. They admit none but their own poor on favorable terms. They are remote from us and their treatment is feeble compared to the lofty conceptions of truly combined medical and moral management."

Dr. Todd went on to describe the sort of institution he proposed for Connecticut, stating that "such an asylum should be the reverse of everything which usually occurs in our concept of a 'Mad House.' It should not be a jail in which for individual and public security the unfortunate are confined, nor should it be merely a hospital where they may have the benefit of medical treatment, for without moral management the most judicious course of medication is rarely successful, nor should it be a school where the mind is subjected to discipline while the body continues to suffer in consequence of original or symptomatic disease."

Dr. Todd's proposal was accepted with enthusiasm. The Connecticut State Legislature authorized active incorporation of the institution. It was named "The Retreat" and was chartered in 1822 by the Connecticut Medical Society.

From the very beginning Dr. Todd and The Retreat were dedicated to a program of education and rehabilitation of the mentally ill. "We shall strive to treat those so afflicted as far as possible as rational beings," Dr. Todd said, "to allow all the liberty and indulgence compatible with their own safety and that of others, to cherish in them sentiments and self-respect, to excite an ambition for good will and esteem for others, to draw out the latent sparks of natural and social affections, to occupy their attention, to exercise their judgment and ingenuity, and to administer to self-complacency by engaging them in useful employments alternated with amusements."

Through the years each successive superintendent has striven to improve the hospital's rehabilitation facilities and to vary its activities. In The Retreat's early days, necessity confined these activities for the most part to farming and maintenance. But gradually the value of expanded recreational activity was fully appreciated.

STRIDES TOWARD PROGRESS

Rehabilitation made great forward strides during the tenure of Dr. John S. Butler who guided the hospital through the Civil War and Reconstruction eras. Dr. Butler acquired the physical facilities which he considered to be essential. Then he divided the patient population into groups; members of each group lived, worked, and socialized together, and had their own recreation yards. He watched and evaluated the interaction of the patients' personalities. As his experience broadened, Dr. Butler became convinced that personalized treatment was possible only in small hospitals. He stressed the need for amusement and recreation, and appealed for funds to build a conservatory, a bowling alley, and a small building to be used as a museum and reading room. He procured books, a melodeon for the chapel, and a piano for the new amusement room.

Dr. Henry Putnam Stearns succeeded Dr. Butler and piloted The Retreat for the next 31 years. He also strove for more effective rehabilitation within the hospital, and for greater community acceptance of the mentally ill.

Modern, functional, rehabilitation building has housed the department of educationl therapy since 1958.

In 1931 under the energetic leadership of Dr. C. Charles Burlingame, the department of educational therapy was organized. Revaluation and expansion of activities gave them a broader connotation which encompassed a variety of functions as essential and integrated parts of the total psychotherapeutic program.

Emphasis was placed on the program's educational aspects in an effort to depart from the "keep-the-patient-busy" philosophy which was so prominent up to this time. The goal was to help the patient achieve more realistic and objective ways of thinking and acting, and acquire concrete physical and social skills which would facilitate his reintegration into the community.

DREAM BECOMES REALITY

Old facilities were modernized and new ones built, including a building with a swimming pool, squash court, and physical therapy section. Physical education received more attention. Social activities were expanded to include lecturers, artists, and musicians from the community so that patients could continue to pursue their cultural interests.

A special activity program, supplementing regularly scheduled classes, was established for each residential unit. It soon became apparent that education is part of the larger process of habilitation or rehabilitation of patients. An ever-increasing number of academic opportunities were made available; these covered a broad range from simple, practical courses to the more advanced college extension courses in science and the humanities. New subjects were added, such as cooking, first aid, home nursing, modeling, sculpturing, music, and typing.

Dr. Burlingame recognized dynamic rehabilitation to be an essential part of the total therapeutic effort. He developed a solid corps of trained instructors; specialists in the various arts and crafts, physical education, home economics, commercial arts, and other avocational, social, and recreational areas. His aggressive, ambitious, and far-reaching rehabilitation program was a pioneering effort to gain recognition of the importance of educational therapy to psychiatric treatment.

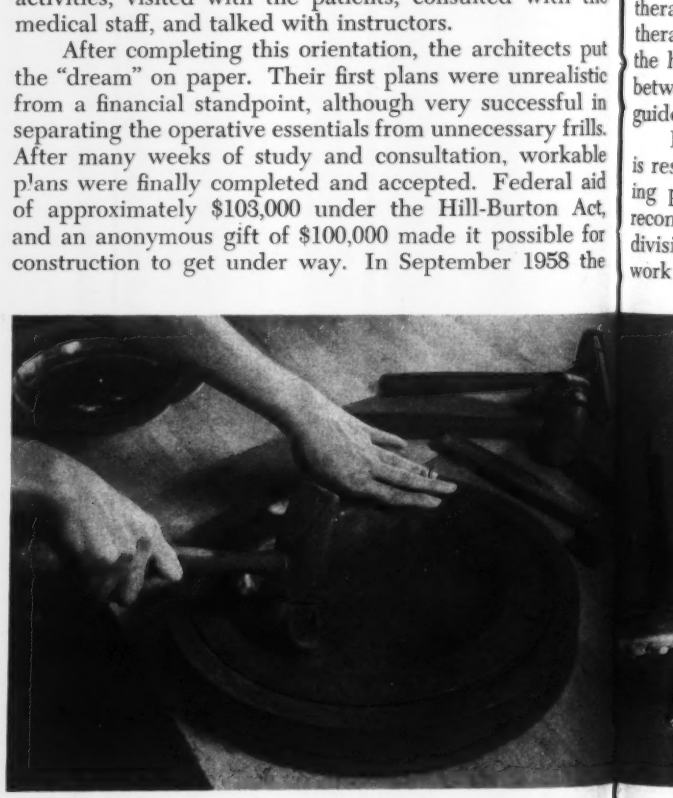
During Dr. Burlingame's era, the name of The Retreat was changed to "The Institute of Living."

In July 1951, Dr. Francis J. Braceland, who had been chief of the section of psychiatry at the Mayo Clinic, became psychiatrist-in-chief at the Institute. He, too, was interested in rehabilitation and in the therapeutic community. The Institute, under his guidance, made additional progress in opening up more diversified outlets for the patients.

Dr. Braceland believed that the department once again required expansion and modernization. The building which housed most of the activities was 135 years old, and the staff's dream was to have a new rehabilitation building; a gymnasium, an auditorium, and larger social and recreational areas were needed.

A grant of $209,000 from the Ford Foundation paved the way for initiating plans for construction. In the early planning stage it was necessary for the architects to have an opportunity to "feel" the needs of the patients. To accomplish this, they came into the hospital, attended the activities, visited with the patients, consulted with the medical staff, and talked with instructors.

After completing this orientation, the architects put the "dream" on paper. Their first plans were unrealistic from a financial standpoint, although very successful in separating the operative essentials from unnecessary frills. After many weeks of study and consultation, workable plans were finally completed and accepted. Federal aid of approximately $103,000 under the Hill-Burton Act, and an anonymous gift of $100,000 made it possible for construction to get under way. In September 1958 the



Metalwork is a popular activity in the crafts division.

Cooking and other domestic arts appeal to many women patients because these activities are similar to those they hope to take up again in their own homes.

rehabilitation building was completed at a total cost of $832,000. It is attractive, modern, functional, and very adaptable.

When a patient enters The Institute of Living, the psychiatrist assigned to him determines his rehabilitative needs, and recommends a tentative program for him in the department of educational therapy. Through selected activities the patient is given every opportunity to express conscious and unconscious feelings, and to focus his energies in a constructive manner.

Within a week after the patient's admission, his personal physician also writes a prescription with specific recommendations to instructors. He includes an outline of the patient's occupational interests; his vocational, avocational, and social interests; his clinical history, and his current mental and physical status. Staff briefings by the director or the assistant director of educational therapy supplement this prescription for the instructors. As treatment progresses, changes are made in the patient's schedule on the basis of the educational therapists' conferences with him and with the psychiatrist.

STAFF STRUCTURE

The director and assistant director of the educational therapy department are both registered occupational therapists, directly responsible to the medical director of the hospital. A senior staff psychiatrist serves as liaison between the medical director and the department, and guides the formation of department policies.

Each of the department's seven division supervisors is responsible for enforcing general policies and informing personnel about current procedures and treatment recommendations. Every area of education within the divisions is taught by either one or two instructors who work directly with the patients. Selection of these instructors is of paramount importance since they are in constant close contact with patients and must regard themselves as therapeutic tools. In addition to aiding, instructing, and directing the patient in developing greater skills, the instructors are very significant figures in his interpersonal world.

During the past year the academic division offered 119 courses in 38 different subjects; instruction is arranged on varying levels depending upon the requirements and academic standing of the patients. The home schools of patients on the junior or senior high-school level are consulted to insure continuity of study, and to make certain that the Institute meets their standards of accreditation. When a patient has been attending public school prior to admission, his local Board of Education requirements must be met. During 1960, communities in 21 states helped to establish satisfactory individual academic programs. Six foreign countries were consulted for the same purpose.

The academic division also includes a section in commercial arts, where both vocational and avocational instruction is given. On the college and graduate levels it offers university extension courses, with individual tutoring when necessary. These courses can be taken on either a credit or a noncredit basis, depending on the patients' needs and their physicians' recommendations. There are two full-time instructors on the staff, and 11 tutors from the local area are available to assist them.

The Hartford area is fortunate in having many educational institutions. When it is therapeutically indicated, patients are permitted to leave the hospital grounds daily to attend regular high school, college, and commercial school classes.

A new patient library is now under construction. It will have a capacity of approximately 12,500 volumes, and will include periodical and reference sections, a study, and a reading room. As in the past, books not available in the hospital's library will be procured from the Hartford Public Library.

The fine arts division includes music as well as art.

A patient's skillful fingers create beauty in leather.

A full-time music therapist on the staff gives private piano, organ, and voice lessons. Other private or group music lessons are arranged with local instructors, and there are regular group classes in music appreciation and singing. All patients who take music lessons are expected to practice a minimum of four times each week for half-hour periods in soundproof rooms which are available to them.

The art studio employs two full-time instructors and offers private and group classes in sculpturing and the use of oils, watercolors, pastels, and tempera. The atmosphere of the studio is comparable to that of similar settings outside the hospital. Weekly art-appreciation classes include lectures illustrated with slides, films, and demonstrations.

In the crafts division, patients may work in the hobby shop or attend classes where they learn to make articles in leather, metal, or ceramics. No charge is made for instruction in group classes, but all patients purchase their own materials. Each class has two instructors. Projects vary in complexity and length, depending upon the patients' interests and aptitudes. In the hobby shop, for instance, a patient may be sanding a breadboard, an activity requiring a minimum of effort and concentration; another may be assembling a hi-fi set requiring prolonged concentration and well-developed manual dexterity.

The domestic arts division consists of sewing, knitting, embroidery, and cooking. Sewing, a very popular activity, is taught by two regular instructors; the other classes each have one instructor. Many women patients are particularly fond of these activities which are similar to those they enjoyed in their own homes.

SOCIAL ACTIVITIES

The social activities area has been designed to provide an informal setting conducive to relaxation. Two full-time social supervisors guide activities, such as ballroom dancing classes, play reading, weekly dances, dinner parties, and cook-outs. They also plan all of the evening entertainments, which are sometimes sponsored by community sources. Programs are varied and include concerts, movies, book reviews, demonstrations, fashion shows, and dog shows.

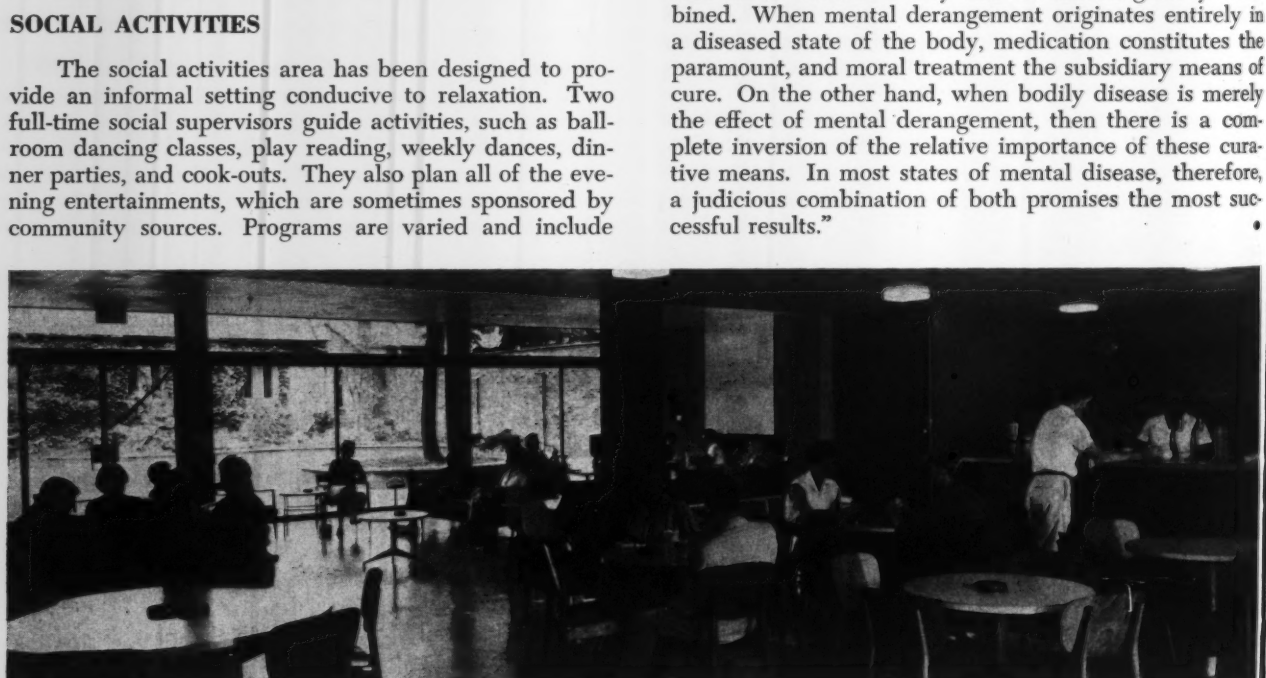
Four full-time instructors supervise the physical education division and the recreation area. According to the season, patients swim in either an indoor or an outdoor pool, and during warm weather they are especially enthusiastic about softball and tennis. The indoor recreation area is in almost constant use for ping-pong, shuffleboard, pool, billiards, bowling, and gymnastics.

Physical therapy is under the supervision of a licensed therapist who is aided by a trained male assistant. The patients' personal physicians refer them to this division by prescription. All standard physical therapy modalities are available.

THE "JUDICIOUS COMBINATION"

Frequent staff meetings within the department of educational therapy and between its division instructors and the medical staff assure a smooth, uninterrupted flow of communication. During these meetings broad planning is reviewed, policies are proposed, mutual problems are discussed, and, hopefully, solutions are found.

This kind of communication fosters steady improvement of the educational services that have emanated from continued application of Dr. Todd's philosophy. His enlightened viewpoints concerning the necessary collaboration of medicine, psychiatry, and therapy are as pertinent today as they were 140 years ago when he said, "It is by no means intended to exclude the aid of medicine. For, as before observed, the mind and body are so connected that there can scarcely be a disease of either in which the other is not involved, and in which medicine and moral treatment may not be advantageously combined. When mental derangement originates entirely in a diseased state of the body, medication constitutes the paramount, and moral treatment the subsidiary means of cure. On the other hand, when bodily disease is merely the effect of mental derangement, then there is a complete inversion of the relative importance of these curative means. In most states of mental disease, therefore, a judicious combination of both promises the most successful results."



Nonhospital atmosphere of the social activities area stimulates informal get-togethers and relaxing conversation.

I. History, significance, and potential impact of the report of the Joint Commission on Mental Illness and Health

New Perspectives on Mental Patient Care

ROBERT L. ROBINSON, M.A.
Public Information Officer
American Psychiatric Association
Consultant to the Institute Program Committee
Washington, D. C.

IT IS ALMOST INCONCEIVABLE that the Program Committee this year would do other than direct the attention of the Mental Hospital Institute to *Action for Mental Health*, the final report of the Joint Commission on Mental Illness and Health. Not since Dorothea Dix in 1848 proposed setting aside 10 million acres of public lands to be sold to finance programs for the mentally ill has so bold a manifesto been set down in their behalf.

The whole of this report is greater than the sum of its parts. It will attract the flexible thinker and trouble the rigid thinker, be they liberal or conservative. Selected audiences will recoil at parts of it and spring to the support of others.

To begin with, *Action for Mental Health* is superbly written. It eschews jargon. It is concise. The words tell. The lines are straight and trim. Indeed, someone has commented that "the report is too well written." Can anything be too well written? Take this excerpt, for example:

> "The hospital must cease to be treated as a target for political exploitation. Patronage must end; appointments to jobs in state hospitals must not be made on a political basis if we have any intention of improving these hospitals. The hospitals and their logical community extensions—clinics and aftercare programs—must be manned in all cases by properly motivated career workers and not, as in so many instances in mental hospitals, by hacks, professional or lay. Too many persons who are alcoholics, addicts, professional misfits, or otherwise mentally ill themselves have been given mental hospital positions all the way from attendant to superintendent. Happily, there is now apparently a shift toward greater competence. There is no cheap, quick method by which we can raise the level of care for mental patients, any more than there are short cuts to high class care in general hospitals. The personnel must be well paid and well trained, professionally or vocationally."

Old timers at A.P.A. Mental Hospital Institutes will recall that the spark that ultimately inspired the Congress to appropriate $1,250,000 for the Joint Commission's work was struck in October 1953 by Dr. Kenneth Appel, then A.P.A. President, at the Fifth Mental Hospital Institute in Little Rock, Arkansas. In his address to the Institute that year, Dr. Appel reviewed the sorry state of affairs in the vineyards of mental health and hospitals at the time.

He elaborated his sense of outrage at what he viewed as massive social rejection of the mentally ill, and wound up his address with: "One more suggestion, and I am finished. We ought to have a sociological study of the breakdown crises in the administration of state mental hospital functions . . . We had a Flexner Report on medical education. We had a study of the American College of Surgeons which tremendously improved efficiency of our general hospitals. It seems to me that we need a 'Flexner Report' on public hospital administration. A neutral body should make such a study."

IDEA CATCHES FIRE

However, Dr. Appel's statement that he was finished was premature; he had only started. Having struck the spark, he was up to his neck in the conflagration that followed, and contentedly so. Dr. Leo Bartemeier, Chairman of the Council of Mental Health of the A.M.A., took up the torch and further elaborated the need for a Flexner-type study and report. The founder of the Mental Hospital Institutes and the then A.P.A. Medical Director, Dr. Daniel Blain, rallied his forces to transmute the proposal into action; and any number of other stalwarts lent a hand.

The proposition was then taken up to "The Hill" in Washington, where several senators and congressmen lent it a sympathetic ear, notably among them, Senator Lister Hill and Congressmen John Fogarty and the late

This is the first in a series of articles on the final report of the Joint Commission. The series is sponsored by the Program Committee for the 13th Mental Hospital Institute, and is intended as orientation material for the Institute discussions. Subsequent papers in the series will be written by members of the committee.

Percy Priest. These champions of the fight against mental illness mustered over a score of congressional colleagues to sponsor the Mental Health Study Act of 1955.

CONGRESS LENDS SUPPORT

"It is the sense of the Congress," read the Act, "that there exists a critical need for such an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness and of the resources, methods, and practices currently utilized in diagnosing, treating, caring for, and rehabilitating the mentally ill, both within and outside of institutions, as may lead to the development of comprehensive and realistic recommendations for such better utilization of those resources or such improvements on and new developments in methods of diagnosis, treatment, care, and rehabilitation as give promise of resulting in a marked reduction in the incidence of duration of mental illness, and, in consequence, a lessening of the appalling emotional and financial drain on the families of those afflicted or on the economic resources of the States and the Nation." And further, "It is declared to be the policy of the Congress to promote mental health and to help solve the complex and interrelated problems posed by mental illness by encouraging the undertaking of nongovernmental, multidisciplinary research into and reevaluation of all aspects of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill . . ."

Backbreaking sentences these! Still, they left no doubt of the spirit and intent of the Congress in authorizing the National Institute of Mental Health to grant the money needed to carry out such a nationwide analysis.

While the legislative mill was grinding out the detailed provisions of the Act, the American Psychiatric Association and the American Medical Association, in the spring of 1955, organized the Joint Commission on Mental Illness and Health as a study group which would be eligible to receive the grant money if the Act passed the Congress—which it did, without a dissenting vote, in July 1955. Soon thereafter the Joint Commission applied for and received the appropriated funds from the National Institute of Mental Health. The work of the Commission got under way in the fall of that year. (Note: Later the Commission received NIMH supplementary grants totaling $160,000, and funds from private foundations totaling $137,000.)

Since the study was to be an interdisciplinary effort, thirty-six national organizations, including A.P.A. and A.M.A., appointed forty-five representatives to serve on the Joint Commission, bringing to the task as complete a spectrum of approaches and points of view as could reasonably be marshalled. General science, pediatrics, neurology, general medicine, psychiatry, child psychiatry, social work, nursing, psychology, occupational therapy, personnel and guidance management, psychoanalysis, public health, public welfare, physical, mental, and vocational rehabilitation, medical education, hospital administration, religion, state government, justice, education, veterans, and citizens, groups—all of these were represented in the membership of the Commission, through appointments by professional organizations and agencies.

It is pertinent to emphasize at this point that the members of the Joint Commission, once appointed by the organizations and agencies concerned, served on the Commission in their individual capacities, with freedom to guide the work of the Commission according to their personal judgments rather than as the committed delegates of a professional organization or agency. (It is of interest that in this individual capacity, forty-two of the forty-five members of the Commission approved *Action for Mental Health.* Three members abstained, each protesting specific recommendations. Thus it was wisely projected that if the intent of the Congress were to be realized, the Commission could not cast its recommendations as binding on any organization or agency. It was understood that while the report as a whole might receive broad acceptance in spirit and principle, its specific recommendations would have to be thrown into a thousand market places, such as the Mental Hospital Institute, for debate and discussion to determine the degree of acceptance ultimately accorded them.

Extreme good fortune graced the Commission when Dr. Jack Ewalt was persuaded to direct its work, and when he, in turn, prevailed upon Mr. Greer Williams to be the director of information. It is to this unique and able combination that we owe the depth and clarity that characterize *Action for Mental Health.*

PLANNING COMMITTEE FORMED

One of the Commission's first steps was to delegate a committee to plan the study. This committee further crystallized the spirit of the Congress when it said: "The Commission should act on a conviction that the solution of the problem of mental illness in America is far more important than the preservation of any tradition, institution, procedure, alignment of professional responsibility, or set of theoretical assumptions . . . The Commission should be ready to recommend radical reconstruction of the present system, if such is indicated." The Commission found that such was indicated.

Despite its title, *Action for Mental Health* is focused primarily on mental illness. The Joint Commission delved intensively into the concept of mental health and the feasibility of "promoting it" in a positive sense. But the Commission was no more successful than any other group in formulating a scientific definition of mental health.

Consultants galore, names known to all sophisticated in mental health disciplines, were mustered to share in a venture that called for "not only a good deal of insight but also some daring, if not downright rashness," as Director Ewalt notes in his introduction to the final report. Organized into various committees and subcommittees, there were consultants on education, mental health, manpower, public opinion, research, religion, community resources, epidemiology, and patterns of patient care. The work of the Commission has extended over five years, in the course of which ten monographs have been produced as a prelude to the final report. All of these are (or in some instances will be) published by Basic Books and

merit careful study by those who would analyze more carefully the distillations of the final report. They are:

Current Concepts of Positive Mental Health, Marie Jahoda, Ph.D., $2.75

Economics of Mental Illness, Rashi Fein, Ph.D., $3.00

Mental Health Manpower Trends, George W. Albee, Ph.D., $6.75

Americans View Their Mental Health, A Nationwide Interview Survey, Gerald Gurin, Ph.D., Joseph Veroff, Ph.D., Sheila Feld, Ph.D., $7.50

Community Resources in Mental Health, Reginald Robinson, Ph.D., David F. DeMarche, Ph.D., Mildred Wagle, M.S.S.A., $8.50

Epidemiology and Mental Illness, Richard J. Plunkett, M.D., and John E. Gordon, M.D., $2.75

The Role of Schools in Mental Health, Wesley Allinsmith, Ph.D., and George W. Goethals, Ed. D. (in press)

The Churches and Mental Health, Richard V. McCann, Ph.D. (in press)

New Perspectives on Mental Patient Care, Morris S. Schwartz, Ph.D.; Charlotte Green Schwartz, M.A.; Mark G. Field, Ph.D.; Elliot G. Mishler, Ph.D.; Simon S. Olshansky, M.A.; Jesse R. Pitts, Ph.D.; Rhona Rapoport, Ph.D.; and Warren T. Vaughan, Jr., M.D. (still in preparation)

Research Resources in Mental Health, William F. Soskin, Ph.D. (still in preparation)

Some of the report's authority will derive from its humility. As Dr. Ewalt says in his introduction, the purpose is "to develop a plan of action that would satisfy us that we are doing the best we can," and "even if we can find the road to a substantial reduction in the human and economic problems of mental illness . . . we are obliged to keep in full view certain intervening observations that provide little cause for hope except as we can dispose of them . . . To state the case truthfully and place the reality of *what is* side by side with our pretension as a preponderantly Christian, democratic, humanitarian, scientific, productive society can only serve to embarrass us. But how else can we reap the profit of history's 'lesson'?"

Action for Mental Health illuminates some aspects of public relations and education that have been buried under semantic debris for years. For example, here is how the report deals with the common platitude, "Mental illness is just like any other illness":

> "Major mental illness is different from physical illness in the one fundamental aspect that it tends to disturb and repel others rather than evoke their sympathy and desire to help. . . . We have not succeeded in telling or showing the public what major mental illness is like, in detail or as a whole, and therefore have not provided sufficient factual understanding and involvement to do away with the popular stereotype of the 'raving maniac' or 'madman' as the only kind of a person who goes to mental hospitals. We have not made it clear that such persons who are wild and out of control exist, but in a somewhat similar proportion to airplanes that crash in relation to airplanes that land safely."

One often hears it said of psychiatry and the other mental health disciplines that they do not "think big enough." Fearing that they will be laughed out of the legislative hearing room if they state what their needs really are, they ask for too little. Expecting a turndown, they receive it. Nor can one help recalling in this context the old-time superintendent who so relished the accolade he received from the appropriations committee when he was able to turn back a few thousand dollars to the general fund at the end of a year!

Well, *Action for Mental Health* "thinks big enough" to add luster to the heartiest hue of resolution. It dispenses once and for all with the notion that an increase in per diem expenditures for hospitalized patients from $2.79 to $3.82 justifies uncorking a bottle of champagne. It says, simply enough, if the nation is to overcome the lag in treatment and care of the mentally ill, expenditures must be doubled in the next five years and tripled in the next ten. It poses the Veterans Administration hospital as a feasible model of what can be done in public mental hospitals generally. Where will the money come from? The report envisages a formula for sharing the expense among federal, state, and local governments. In cash, it would mean a total public expenditure in 1971 in the nature of $3 billion, about 58 per cent of which would be federally appropriated—and all of this in addition to whatever the Federal Government may appropriate for its ongoing research and training grant programs.

As the report puts it, this is the first proposal in American history that attempts to encompass the total problem of mental patient services and to make minimum standards of adequate care financially possible. It proceeds on the assumption that any national program adopted by Congress and the states against mental illness must be scaled to the size of the problem, imaginative in the course it pursues, and energetic in overcoming both psychological and economic resistance to progress.

FOCUS ON THE PATIENT

Unquestionably, *Action for Mental Health* is a radical report, not in the extreme political sense of the word, but in the sense of seeking to probe to the roots of the trouble. Thus, with gloves well padded, though not with velvet, the Commission approaches the problem of mental health manpower and its utilization. It suggests, among other things, that the mental health professionals take a second look at the criteria which they customarily pose as prerequisite to therapeutic success with a patient. And this book never forgets its subject—the mental patient. Witness, for example, this excerpt:

> ". . . The therapeutic truth as it applies to psychotics and other forms of major mental illness appears to boil down, then, to what the public action slogan suggests. Mental illness is 'everybody's business.' This is the potentiality we must exploit as a means of resolving the manpower problem. It has been commonly observed that certain therapists, both medical and lay, have an x-factor, as some have called it, a 'healing touch' or a 'winning way,' that

enables them to achieve a therapeutic relationship and good results with certain patients where others may fail. . . . Most of us in the mental health professions would agree that there is 'something to this,' and also might concede that the *something* is not necessarily measured by doctoral degrees, board certificates, or licenses to practice. The principle that must guide us in questions of authority, professional prerogatives, and qualifications involved in treatment of the mentally ill now readily emerges. The only principle that can satisfy all interested parties, including the public, is one of individual competence to undertake a given approach to a patient. . . ."

This article is merely the opening gun in a series to appear in MENTAL HOSPITALS over the next few months—all to build up appetite and information as prelude to constructive discussion at the Omaha meeting in October. Naturally we have sought to stimulate our readers' taste buds with some of the juicier tidbits of the report.

The reader will do well, however, to dispense quickly with the tidbits and post at once to the rich harvest table that the full text provides. Mental hospital workers will influence and be influenced by this report for many years to come. They owe it to themselves to become thoroughly acquainted with its scope and the potential of its impact.

THE BUCK STOPS HERE

By DR. WHATSISNAME

ONE OF THE MYTHS about the Organization Man is that he can say "no" in a way that will satisfy any petitioner. This smacks of the magical, and like most magic, it doesn't work. No one knows this better than the superintendent of a mental hospital, who is faced with the constant necessity of ruling against employees, visitors, patients' relatives, salesmen, or job applicants. If he "yesses" indiscriminately, he forfeits the respect of his staff and becomes the butt of jokes. Whenever he says "no," he is bound to dismay someone.

Consider the classic situation of a superintendent confronted by an employee presenting a doubtful excuse for an absence. The superintendent who invariably accepts the excuse is dubbed a patsy; a rejection reaps enmity because it costs the employee hard cash.

Sometimes a decision concerns an abstract issue, uncomplicated by personal implications. More often, a ruling in favor of an idea, policy, or person is a decision against another person—or is one which rejects a recommendation. Just as a chess player can't say "checkmate" without sounding smug, so a rejection cannot be made to sound like an approval. (It can—for a short time—if the executive is cynical and opportunistic, but this doesn't last.)

A superintendent has to make decisions—and in the long run, to make decisions is to make enemies. Unless an employee is a saint, he will dislike the executive who causes him to lose face—or funds. True, many of us recall commanding officers in our Army or Navy days, and we now say: "The Old Man was tough, but he was fair and square and you had to respect him for it." That's the way it looks through the glow of 15 years, but back in 1945 you had neither affection nor respect for the Old Man who denied you a pass, or a promotion, or anything else you knew you were entitled to.

When it comes to making decisions, the superintendent is no different from any manager or executive in the business, political, or academic world. But these other executives learned early that if you never hurt anyone, you don't climb high on the career ladder. To quote the immortal Durocher, "Nice guys don't win ball games." In these other fields, the rising executives give no conscious thought to the need to be loved. Some, indeed, are powered by a need to be hated. The psychiatrist, one supposes, is more conscious of his need to be loved and of an unwillingness to traumatize people. The physician is brought up in a person-loving atmosphere so that it is harder for him to be ruthless in personal relationships. The psychiatrist, one hopes, is sensitive to the need for saving face and otherwise protecting people; when he becomes a superintendent, he is more poignantly conscious of this dilemma than is the business man who has to handle commodities rather than people.

And then he understands what Seneca meant (in *Hercules Furens*) when he wrote, "To be able to endure odium is the first thing to be learned by those who aspire to power."

The clinical director can concentrate on patients—and can love them all. When personnel problems get too pressing, he can buck them to the superintendent who has to take the "odium" if his decision hurts anyone. One wonders if realization of this ever kept a clinical director from accepting a promotion. As Harry Truman used to say: "The buck stops here." And as he said on an other occasion, "Stay out of the kitchen if you can't stand the heat."

PHILOSOPHY — FUNCTION — FORM

FAMOUS ARCHITECT Frank Lloyd Wright's mentor, Louis Sullivan, stated, during the first part of this century, that "form follows function." In line with this concept, the new Institute of Psychiatry at the Mount Sinai Hospital in New York City is being constructed after—not before—several decades of experience with the function of psychiatry in a general hospital. Further, its planners have incorporated a third dimension, philosophy, in their interpretation of the architect's dictum. Philosophy, function, form—each has played its part in the plans for the new building.

The staff at Mount Sinai believes that the department of psychiatry in a general hospital must be completely integrated with the over-all function of that hospital. This is possible only when the psychiatrist views himself and his medical specialty in a way that not only permits but demands this integration. Under these conditions, his domain ceases to be an isolated psychiatric ward with an appendage called the outpatient psychiatric clinic, and becomes an integral part of the entire hospital.

This basic philosophical approach applies to any department of psychiatry in any general hospital. Certain functions are common to them all. However, just as each hospital differs from every other hospital in certain unique respects, so will each department of psychiatry have its own specific character in relation to its own general hospital.

On these two basic principles—a belief in the psychiatrist as a medical specialist among other medical specialists, and a conviction that the functions of a particular hospital are unique and specific—the department of psychiatry at Mount Sinai has developed.

This is a voluntary hospital with a capacity of 1,136 patients (1,032 beds and 104 bassinets). From its founding in 1852 until fairly recently it had only a limited number of full-time chiefs of services; today it has full-time directors for its major clinical and laboratory departments. In 1920 Mount Sinai became one of the first general hospitals to open a psychiatric clinic. In 1946 the clinic was elevated to the status of a major clinical division, and became the department of psychiatry. Pending the completion of the new institute, which will be able to accommodate 157 patients (117 beds plus 20 beds for 40 patients in a day-night center), we are operating a small two-bed ward for adults, and two beds for children on the pediatric service. There are also a number of outpatient clinics.

Among the questions to be resolved was the relative importance of the three major functions of a hospital: service to the ill, education of attending staff and residents, and research. We also had to decide, within the function of service to the ill, whether primary emphasis

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Ed. Note: This article was prepared from material supplied by M. Ralph Kaufman, M.D., Director of the Department of Psychiatry, The Mount Sinai Hospital, New York City.

should be placed within the hospital (on inpatients) or within the community (on outpatients).

We concluded that the choice must always be primarily in terms of service to the hospital population. We further concluded that within this function of total hospital service, the smaller, less important part of our task is the psychiatric inpatient and outpatient unit itself—and of these two the more important is the outpatient unit. Thus at Mount Sinai we conceive our primary function as being not only to diagnose and treat the specific mental illnesses as such, but to participate in the psychiatric problems of the patient load throughout the hospital.

In doing so, we place strong reliance on voluntary, unpaid service from available professional people. Today, nearly 100 fully trained and experienced psychiatrists give their services without charge for a minimum of six hours each week. Voluntary psychiatrists accepting supervisory responsibility give far more of their time. Other personnel in the department of psychiatry include:

A. Medical consultants
   2 assistant attending and consulting physicians from other services.
B. Nursing staff
   1 head nurse, 1 graduate nurse, 4 student nurses, 1 ward helper, and 3 orderlies.
C. Psychologists
   2 full-time, 5 part-time and 13 externs, 5 of whom are part-time.
D. Social Workers
   9 caseworkers and 8 students.

In addition we have 6 full-time secretaries, 1 full-time and 2 part-time clerks, an occupational therapist, an art therapist, and a recreational worker. Furthermore, academic tutors and speech therapists are attached to each of the child-psychiatry outpatient clinics.

ORGANIZATIONAL STRUCTURE

Our basic organizational structure is simple. We have four major service divisions: child psychiatry, adult liaison, psychiatric outpatient clinics, and the adult ward.

The child psychiatry division is comprised of the ward section (2 beds), the liaison section (all pediatric wards and all pediatric clinics), and the clinic section (2 parent-child guidance clinics, 1 adolescent clinic, 1 group therapy clinic, and 2 psychosomatic clinics).

The adult liaison division is comprised of the hospital section which includes: (a) medicine, medical specialists, and dermatology; (b) surgery and surgical specialists, radiotherapy, urology, and dentistry; (c) neurology and neurosurgery, ophthalmology, otolaryngology, and orthopedics; and (d) obstetrics and gynecology. The outpatient section of the liaison division includes all the hospital's outpatient clinics other than psychiatric.

The four psychiatric outpatient clinics comprise the third service division. One is for individual psychotherapy; one is for group psychotherapy. A third is the follow-up and treatment clinic staffed by residents who follow their own patients after discharging them from the inpatient unit. The fourth adult clinic has been converted into a teaching clinic for general practitioners and specialists who are nonpsychiatrists.

The fourth service division is the adult ward division, with its present 21 beds.

Besides these four service divisions we have the training division for psychiatric residents and fellows, psychologists, social workers, adjuvants, and the general hospital staff; the psychology division, the social work division, the research division, and the special projects division.

MOST IMPORTANT DIVISION

Of all of these, the division of liaison psychiatry is of primary importance. Every service in the hospital has attached to it, depending upon its size, a psychiatrist or a team of psychiatrists. Each of these psychiatrists, while a member of the department of psychiatry and responsible to it, nevertheless functions as a team member of the service to which he is assigned, and fulfills a number of roles. He is a consultant to his service and a teacher for the attending staff and residents; he serves as a diagnostician as well as a therapist on the service, and refers to the department of psychiatry only those patients who require the special diagnostic and therapeutic measures available there. So far as possible, patients remain on the service to which they are admitted. The liaison psychiatrist does not have to wait to be called in, but is free to see patients any time he or anyone else on the service—whether intern, resident, attending doctor, social worker, or nurse—finds indications for psychiatric participation.

The complexity of the liaison psychiatrist's role may best be indicated by a review of a study progressing at the present time concerning the types and categories of patients seen by him.

In a three-year study of 2,309 psychiatric consultations by the adult liaison division, the breakdown reveals that in 61.4 per cent of the cases the problem was one of differential diagnosis; in 26.8 per cent, the problem was frankly psychiatric—schizophrenic reactions, suicidal tendencies, etc.; and in 11.8 per cent of the cases, the requests were for assistance in the total management of the case.

The disposition of these cases is also of interest: 6.2 per cent were transferred to the adult psychiatric ward; 4.2 per cent were transferred to state hospitals; 17.7 per cent were referred to the psychiatric outpatient clinic; and 35.7 per cent were given psychotherapy on the parent ward. Fourteen and seven-tenths per cent were referred to social service, and in 21.4 per cent of the cases there were no "specific recommendations, disposition, or psychopathology."

One minor but significant finding concerned the timing of the consultation request. These patients were seen by the psychiatrist on an average of four days after admission. In similar studies done in the past, the consultation requests came most frequently near the end of the hospital stay, after a negative physical work-up.

The significance of the dispositions of the cases outlined above, and the fact that the patients were seen soon

after admission to the hospital is further highlighted by a review of cases on the psychiatric ward. In 1948, an examination of the diagnoses of the daily census of 18 patients on the ward indicated that 13 had a primary medical diagnosis. As this article was written, an examination of the diagnoses of the daily census revealed that only 4 had primary medical diagnoses.

The increased number of patients with a primary psychiatric diagnosis indicates a number of things. First, the character of the ward population has changed, with the ward receiving many more direct admissions from outside the hospital in preparation for the increased psychiatric beds to be made available in 1962. Second, it seems to us to indicate that the liaison service has become more integrated with the other departments of the hospital, and that many more patients are seen for psychiatric diagnosis and treatment on the medical, surgical, and specialty wards.

A prominent aspect of the hospital's function is the education and training of the psychiatric attending staff and its own resident staff. Education, as we all know, is a continuing process, and the staff membership of any department in a hospital consists of individuals with various degrees of experience. A consistent pattern for our own education as members of the attending staff has gradually evolved. A vital part of this pattern is the conference system which involves frequent departmental meetings.

THE RESIDENCY PROGRAM

The training of residents is one of the most important functions of a department of psychiatry in a general hospital. In our own case, we are accredited for a three-year training program in general psychiatry. Since we do not have the varied clinical material necessary for a complete program, we require our residents to have part of their training in a state-hospital type of situation as part of our own program.

In a sense, we consider our residency training to be a kind of honing process. The emphasis is on psychotherapy and we depend heavily on the preceptor system. The caseload for the resident is a relatively small one, but since he sees patients daily, his over-all work load is rather heavy. In addition to the training offered in general psychiatry, there is a two-year program for training in child psychiatry. Our close working relationship with the department of pediatrics and obstetrics makes this latter program a broad one.

It should be emphasized that the base for the training of a resident in psychiatry in a general hospital is much wider and the opportunities greater than those in a psychiatric hospital. A psychiatric unit in a general hospital presents the opportunity not only of relating medicine to psychiatry, but also of relating psychiatry to medicine. This is true at the resident level as well as at the attending level. There is some danger, however, that the absence of relatively chronic psychiatric patients may constrict a training program in a general hospital. Thus an affiliated program with a specialized hospital is advantageous.

In addition to the service and education functions of psychiatry in a general hospital, there are numerous research opportunities inherent in the setting. The close working relationship of all aspects of medicine encourages collaborative research, and many of our studies are of a collaborative nature.

For instance, an opportunity presented itself over a period of several years to investigate patients with gastric fistulae. This project involved collaboration among the departments of surgery, medicine, gastroenterology, physiology, and psychiatry, and resulted in the publication of a series of papers which made some contribution to each of these disciplines.

In another instance, the liaison psychiatrist working in the departments of neurology and ophthalmology carried out a significant project relating to postoperative reactions of patients with cataracts. The same psychiatrist working collaboratively with the neurologists made some important contributions to the problem of the organic brain syndromes.

COLLABORATIVE DIAGNOSIS

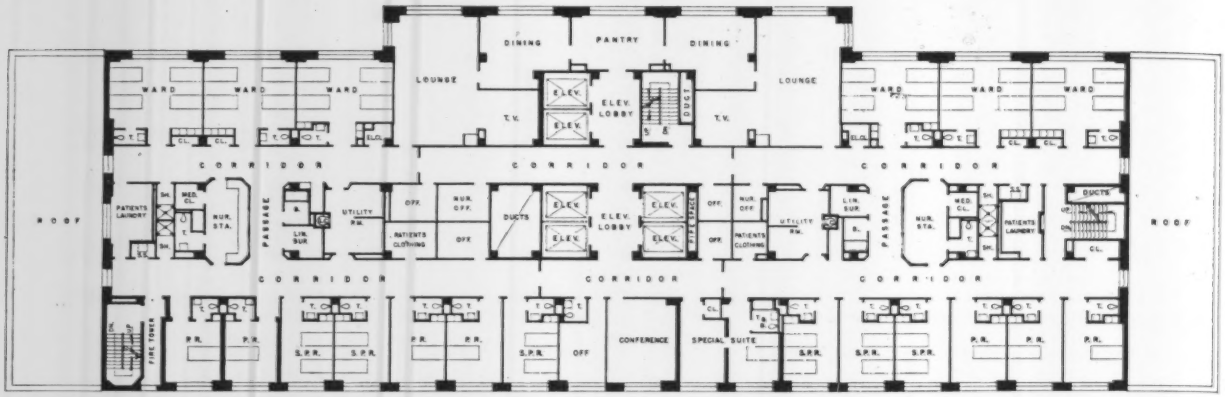
There are many opportunities for the psychiatrist functioning in a general hospital to evaluate the incidence of psychiatric syndromes in the usual caseload of the hospital. One such study was done with one thousand unselected outpatients who presented puzzling diagnostic features. They were examined by the Mount Sinai Hospital consultation service. Examining facilities encompassed all the specialties in medicine and included the most comprehensive laboratory support. After all organic factors could be eliminated, the patients in 81.4 per cent of these diagnostic problems were found to have psychological factors as the basis for their complaints and illnesses. Only 16.6 per cent of the 1,000 patients had organic illness as the sole etiological factor. Emotional illness can and should be a positive diagnosis, not one of exclusion.

There are, of course, numerous research problems within the department of psychiatry itself. The studies now in progress on perception, sleep, and dreams are a major contribution to this field and have thrown light upon many problems in psychoanalytic psychology. Although these particular studies might well have been carried out in another setting, nevertheless the fact that a psychiatric department is part of the general hospital permits a wider variation of subjects and collaboration with other disciplines to carry out various aspects of the project.

THE NEW INSTITUTE

The foregoing, concerned with the underlying philosophy and functions of the department of psychiatry at Mount Sinai Hospital, brings us to a discussion of the new Institute of Psychiatry—how it is being planned to implement the department's philosophy and functions, and how it will influence the department's future development.

The new clinical building, to be completed in early



TYPICAL PSYCHIATRIC PATIENTS FLOOR

SCALE: 0 8 16 32 64 FT.

The seventh and eighth floors of the new Institute will be devoted to single, double, and four-bed units for adult psychiatric patients. Beds for children and adolescents, clinics, a day-night hospital, a recovery unit, and other facilities are located on other floors.

1962 at a total cost of between $8 and $9 million, is the first of three units to be built. Together, they will represent the largest and most significant expansion of the hospital since it was founded in 1852. The nine-story, block-long building, extending from 99th Street to 100th Street on Madison Avenue in New York City, will house 458 beds in all. One hundred and thirty-seven will be for psychiatric patients, the remainder for patients in medicine, surgery, and other specialty services.

The Institute of Psychiatry will occupy the first, sixth, seventh, eighth, and ninth floors of the clinical services building. On the first floor will be the adult, adolescent, and children's outpatient psychiatric clinics, each with a separate entrance and waiting rooms. Approximately 50 rooms will be assigned to clinic staff members—psychiatrists, social workers, psychologists, and other personnel. There will be, in addition, adequate record-room facilities, a secretarial pool, and other space necessary for the administrative aspects of the services. With this much space available—badly needed since our clinics have currently spilled over into a neighboring city-housing project—it is hoped that each clinic team will function on a twice-a-week basis, and that the outpatient department will be open five and one-half days. Later, an evening clinic may function at least one night a week.

On the sixth floor, treatment facilities will consist of a fifteen-bed children's psychiatric unit, including a six-bed adolescent unit, part of a special research project partially supported by the Jack Martin Fund and designed to investigate the emotional components of juvenile delinquency; a twenty-bed day and night hospital; a classroom; and a somatic therapy section with a twelve-bed recovery unit. In addition, there will be adequate recreation, dining, and reading space; staff-physician and clerical offices; and house-staff quarters of eight double rooms, a lounge, etc.

The seventh and eighth floors will be devoted to the adult inpatient psychiatric units. These will consist of four adult wards of 22 beds each. In line with current concepts of patient care, the wards will consist of 1, 2, and 4-bed units. There will also be a special suite to accommodate two more beds. Conference rooms for seminars, teaching, and ward conferences will be located in places convenient to the wards, as will a number of private offices.

Both private and staff patients—all of whom will be available for teaching purposes—will be admitted to the adult inpatient unit. The attending staff will be able to refer private patients for hospitalization when indicated, and continue to treat them within the unit. The patient's medical need, rather than his ability to pay, will determine whether he is assigned to a single or multiple-bed room.

The ninth floor will contain a gymnasium which can also be used as an auditorium, a canteen, and occupational and recreational therapy departments serving the entire hospital.

RESEARCH LABORATORIES

Theoretically, then, the institute's new facilities are designed to care for 157 patients during any 24-hour period. Since less than 100 per cent occupancy increases the flexibility of a program, we hope we will never have all the beds occupied. Even so, the number of patients we will be able to care for will be quite a contrast to the 138 patients admitted last year to our present twenty-one bed unit.

In addition to the service facilities just described, there will be approximately 15 special laboratories assigned to the institute. These, including a special EEG research unit, are being designed to meet our future research needs.

The effect this increased patient population—and these increased research facilities—will have upon our residency program can be readily imagined. Currently accredited for three years, with fourteen residencies available, the training program will be enlarged to include ten residents at each of the 1st, 2nd, and 3rd-year levels of adult psychiatry, and 10 trainees in the child

psychiatry program which was recently approved by the American Board of Psychiatry and Neurology. In addition, it is expected that there will be 6 to 10 Fellows in their 4th, 5th, or 6th year of training, working as teachers and investigators.

UNUSUAL PRECEPTORSHIP

The residency program as a whole will be carefully integrated into the total general hospital. It will utilize the liaison-psychiatry aspects of the present program, which enable all residents to work with all types of medical and surgical problems. It will also take advantage of the fact that the voluntary attending staff, who also teach, represent practically all areas of private practice, from general psychiatry to psychoanalysis. Working with the attending psychiatrist and his patient, the resident will participate actively in the general work-up, diagnostic formulation, and the therapeutic program. Thereafter, in contrast to the usual procedure whereby the resident reports to the preceptor, the preceptor will report to the resident on the course of hospitalization of the private patient.

Residents will receive thorough training in the basic biological sciences, neurology, and neurophysiology, working, for varying periods of time, with the department of neurology at both the basic science and clinical levels.

Second-year residents will work in the adult and child psychiatry outpatient divisions in about a two-thirds to one-third ratio during the year, and some will spend six months at a state hospital. With the availability of the twelve-bed somatic therapy unit, systematic training in these therapies will also become possible, and assignment to the day and night hospital will further enrich the resident's experience.

The additional research facilities will enable the resident in the advanced stages of his training to participate in some of the ongoing research projects. Here again, the fact that Mount Sinai is a general hospital will influence the resident's development, for it has been our experience that our basic and clinical research problems differ from those in a psychiatric hospital.

One often hears somewhat contemptuous comments about bricks and mortar, and it is true, of course, that well-trained, highly motivated personnel can perform the three major functions of service, instruction, and research, even in shabby quarters. However, we at Mount Sinai believe that the form of physical surroundings must complement and exemplify both function and philosophy if the personnel are to perform with the highest efficiency and competence. We are convinced that our new institute will provide a maximum opportunity for the staff of the department of psychiatry to function at its highest level. •

Have You Heard?

COMMUNITY ACTIVITIES: In an effort to help stamp out the stigma of mental disorders, the *National Radio Network of Belgium* recently broadcast a program of music by such composers as Ravel, Wolf, Chabrier, and Moussorgsky, all of whom were mentally ill at one time or another.

RESEARCH: A study of how witch doctors in Nigeria treat the psychiatric illnesses is planned by the research section of the *Allan Memorial Institute* in Montreal. Certain herbs and the "magical" element used by the native doctors will be studied, on the theory that these may have value in Western medicine.

A World Health Organization Expert Committee on Mental Health, which met some time ago in Geneva, Switzerland, decided that research on an international as well as on a national scale is necessary if further advances are to be made in preventing mental illness. The committee defined areas of priority for mental health research, placing high on the list such subjects as brain function, social attitudes, effect of cultural change, psychoses of the aged, effects of nutrition, and genetic factors. The administration of mental health programs was also recommended as a study area.

It was suggested that research was needed on the kinds of stresses to which high-policy makers and top administrators are subjected. One opinion was that the stresses in high position are too great for normal people, and consequently persons with psychopathic make-up often become leaders. Studies in different cultures might perform a useful function by promoting knowledge of what is required for leadership roles.

Hospital facilities throughout the world will receive special attention. The sizes and kinds of mental hospitals best suited to meet the needs of various types of patients —acute, chronic, recurrent, of different ages, with different symptoms, and in different geographical areas—will be studied.

HOME CARE: GERIATRICS magazine reports that as a result of home care plans in Greenwich and Hartford, Conn., one telephone call from a physician can bring to his patient's bedside not only nursing but homemaker services; loan of a hospital bed, wheel chair, or other equipment; physical, speech, and occupational therapists, health supervision and counseling; and social welfare assistance. These services are supplied by a number of specialized agencies working together in a concerted plan, with the patient's own physician in charge. In this way, home care focuses on each patient in his own home the services of the Visiting Nurse Association, the Family Service Society, the American Red Cross, or other appropriate organizations.

An unorthodox approach to a fundamental problem.

Maximizing Therapeutic Inefficiency

By STANFORD H. SIMON, Ph.D.
Chief, Clinical and Training Section
Psychology Services
VA Hospital, Tomah, Wisconsin

AS EVERYONE KNOWS, psychiatry is making great advances in alleviating many of the conditions of mental illness. This is a boon for mental patients, but some persons who minister to them regard it as a cause for uneasiness. After all, progress might bring on a mental health epidemic and jeopardize the job security of hospital personnel. For this reason some staff members might find it prudent to impair the treatment program in their hospitals. It is for them that the technique of *chaises musicales* is described below.

PLOT FOR CONFUSION

A fundamental assumption underlying this technique is that even the best staffs are limited as to the number of patients with whom they can work. If the number of patients is increased beyond this limit, the staff's efficiency is decreased. One might argue that even hospitals with small staffs are managing to rehabilitate and discharge a disturbing number of patients. How does this happen? Most likely it is because the hospital's treatment teams are concentrating their efforts on the most promising patients.

It is obvious, therefore, that increasing the patient-to-staff ratio will not necessarily decrease the efficiency of even the smallest staffs; we must also decrease the amount of staff time available for any given patient. This can be accomplished in two ways—either by periodically rotating the patients among the various areas of the hospital, or by rotating the staff.

Frequent movement of patients or staff is the essence of the principle known as *chaises musicales*. The principle's beauty lies in its simplicity and dynamic qualities. Stated in scientific form it reads: as intra-hospital movement increases, extrahospital movement decreases. Although the movement of patients has certain advantages over the movement of staff, both can be devastatingly effective in disrupting the treatment program.

Now, how do we increase the transfer of patients to best meet our purposes? The answer, of course, is

It is hoped that this paper, while satirical, will help to clarify the issue it raises. It has been reviewed by the publications committee of the VA Hospital, Tomah, Wis. The opinions and conclusions are the author's own and do not necessarily reflect those of the Veterans Administration.

organization. Organize the treatment program so that it necessitates frequent transfers; since all hospitals do this to some extent, the problem is to maximize the situation. Some of the more common techniques now in use require that patients be transferred to other sections when they: (1) start showing improvement; (2) begin to decompensate; (3) need to receive certain therapeutic activities which may be available only to patients in a particular building; (4) reach a certain age; (5) get grounds privileges.

Another fine method is to consider predischarge planning and/or actual discharge only in an exit unit. Or perhaps we could consider unexploited factors, such as changes in the patient's ataractic medication, height, or weight. Has he grown an inch? Has he lost a pound? These questions lead us to the exciting possibility of utilizing combinations of these variables to speed up the movement of patients. Needless to say, many satisfactions which result from the scientific application of *chaises musicales* depend upon factors uniquely appropriate to the particular hospital.

CHAOS MADE SPECIFIC

Let us now review specific ways in which *chaises musicales* interferes with treatment, and consequently reduces the number of patients leaving the hospital.

- The first and most obvious advantage is that *chaises musicales* increases the number of patients the treatment personnel must get to know and work with in a given period of time. If there are a great many patients, the personnel will feel greatly harassed and their work will suffer accordingly; breakdown in the quality of their work, plus the dilution of their efforts will make them, under ideal conditions, completely ineffective.
- It severs therapeutic relationships which have been helping a patient to improve, or have been sustaining him at his current level of adjustment. Thereby, we are able to get at the very heart of modern psychological treatment and induce a coronary.
- By the same token, it facilitates transferring a patient when he begins to "slip," thus removing any possibility for him to receive continuing support from those he has come to know and trust. This procedure will accelerate his decompensation, or at least retard his remission. In addition, his transfer makes clear to him just how really sick the staff thinks he is.
- It does away with an important therapeutic factor by severing supportive relationships among the patients.
- It ends the relationships between the patients' relatives and the staff. Thus, quite possibly, even those patients who (frustratingly) "remit spontaneously" will not make a successful posthospital adjustment because their relatives have been poorly prepared to deal with them at home.
- *Chaises musicales* makes it extremely difficult, if not impossible, for the treatment staff to observe the patient's course throughout his hospital stay. This, in turn, helps to destroy opportunities for feedback information concerning the effectiveness and worthiness of staff efforts.
- With each section having a different type of patient, *chaises musicales* makes it impossible to compare the effectiveness of the various programs. The programs' weaknesses will remain; their strengths will go unnoticed. Evaluation of new procedures will be discouraged.
- It reduces the chance for healthy competition, and encourages programs to stagnate.
- By limiting the kinds of patients in each building, it also limits the range of problems with which therapists can work. This brings about the desired effect of stultifying the staff.
- It allows the buildings to become nicely stereotyped according to the types of patients they house—regressed, apathetic, etc. This situation helps the patients to learn what is expected of them and how they are to behave—regressed, apathetic, etc.
- It reduces a re-admitted patient's chances of ever returning to the building where he formerly received help. This tends to assure his prolonged stay in the hospital.
- Of course, *chaises musicales* also diverts money and effort into the operations and paper work involved in interbuilding transfers. This keeps these monies and efforts out of the treatment program.

If we diligently apply the principle of *chaises musicales,* we need never fear that a paucity of patients will develop. It may be possible someday, even in fairly large hospitals, to achieve the ultimate: the complete rotation of every patient, through every building, every year. This indeed demands a highly efficient organization to keep the patient movement running along at such a pace. Aspirations beyond this one become breathtaking. •

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By WILMOT D. GRIFFITH, M. A.
Chief Rehabilitation Counselor
Massachusetts Mental Health Center, Boston

LABORATORY FOR PRACTICAL REHABILITATION

WORK IS ONE OF THE MOST VITAL ASPECTS of our society. The vast majority of "normal" people must seek some form of employment and be adequately trained to meet its demands. Therefore, it is reasonable to expect an effective program of psychiatric rehabilitation to include occupational training and experience.

The rehabilitation work program at Massachusetts Mental Health Center is based on this premise. After three and one-half years, we feel the program has proven its value as one of the hospital's major rehabilitation efforts.

We believe that if a patient is to progress toward healthy community living, he must have an opportunity to test his performance in areas in which he has suffered loss or impairment of functions. These usually include work tolerance, the capacity to work with others for specified periods of time, and a subjective feeling of confidence in work and social situations. Our program is organized to give the patient a complete course of work adjustment. Originally, it was conducted under the auspices of the occupational therapy department. Now it is autonomous and places patients in the more than 100 jobs offered by the hospital.

The medical staff refers to the work program patients who are immediately able to profit from it, or who exhibit a capacity for more realistic experience than they have already received in occupational therapy. A referred applicant for the work program follows much the same procedure as does any prospective employee in outside industry. We no longer refer to him as a "patient"; he is known as a "client" instead. There is decided virtue in this switch of terms. When a patient is well enough to take his first step toward realistic vocational rehabilitation, it is consistent with our philosophy and with his growing self-esteem to grant him increased status by calling him a client.

Before we give the client a work assignment, we sift information about him that has been supplied by members of the therapeutic team—psychiatrist, nurse, social worker, and all ancillary services personnel—to determine the work atmosphere that will suit him best. Within the exigencies of the environment, we do our utmost to place clients where their services will not be exploited—unless such exploitation will serve a therapeutic end. For example, a severely incapacitated schizophrenic who is unable to express his hostility might do so if he were placed in a job that would stimulate him to verbalize his feelings.

After referral, the client must present himself at the work program office for an interview. This standard interview gives the rehabilitation counselor an opportunity to appraise the client's work potential, help him to determine which of the available jobs are most appropriate for him, and ascertain his attitude toward work. The client's most important response is his answer to the question: "Why do you think we like to have you work in the hospital?" Answers vary according to the applicant's progress toward assuming social responsibility. His lack of social responsibility may be revealed in a hostile remark—"You want us to do something for nothing."

THE PATIENT GOES TO WORK

When an applicant is accepted, the counselor prepares two cards for him. Each contains essential information relating to the client's prehospital employment, his current drug therapy, the number of hours he is to be employed in the program, etc. The new worker presents these cards to his work supervisor who keeps one and sends the other to the ward. If the client lacks confidence, his counselor will accompany him to the work area; otherwise he goes alone.

The work program offers patients many opportunities to learn practical vocational skills as a by-product of their work assignments, although we do not provide training in new skills. We refer clients to the Massachusetts Rehabilitation Commission for training in a new line of work, or for brush-up courses.

The most popular work areas in the hospital are the clerical room, the kitchen, and the sewing room. The clerical room is supervised by the rehabilitation counselor in charge of the work program. It contains four typewriters, a mimeograph machine, a multilith machine, a duplicating machine, and a composition table. Clients

practice typewriting, operate the various machines, and collate material sent in by the professional departments for processing.

The kitchen, where food is prepared for 300 people every day, is supervised by a graduate dietitian. Here, clients develop skills in serving, in cooking food, and in preparing salads. They also acquire the team skills that are so useful in food centers that specialize in short-order cooking.

The sewing room is directed by two professional seamstresses. Its facilities provide workers with an opportunity to develop skills that can be utilized in both their personal and vocational futures.

Other hospital areas that offer training opportunities are:

1. The reception desk, manned wholly by clients who develop facility in meeting and directing visitors.
2. The gift shop, which provides supervised opportunities to learn techniques of merchandise-management and operation.
3. The storeroom, where workers become acquainted with the hospital's supply problems.
4. The dentist's office, where selected applicants can learn the skills of a dental assistant.
5. The paint shop, where members of the paint crew learn painting techniques from the supervisor.

Other training opportunities are available, but those listed above are used most consistently.

Supervisors fill in weekly time-sheets which record clients' punctuality and the number of hours they work. Once a week the rehabilitation counselor interviews both the supervisor and the worker to determine how much progress is being made.

Counseling is one of the most important aspects of our work program. Our basic philosophy is that success depends more upon the rehabilitation counselor's personal qualities than upon the stereotyped use of specific techniques. Warmth, understanding, acceptance, and sincerity are essential. No theorist can give these qualities to a counselor.

Rehabilitation counselors must be constantly aware of the patients' needs and try to determine and encourage their positive motivations. These motivations may be manifested by the patients' recognition of: (1) a need for work tolerance and for confidence building; (2) a need for useful activity to channel excess energy; (3) a growing desire to return to an active life outside the hospital; and (4) a need to refresh skills impaired by incapacitating illness.

Because we believe that each client has worth, significance, and dignity, we encourage a generally permissive face-to-face relationship between counselor and client. The client remains in close touch with his counselor who keeps him informed about his status, and encourages him as he makes satisfactory progress.

However, the maxim, "Make haste slowly," is particularly applicable to those who work with the mentally ill. The counselor must resign himself to slow progress in achieving positive results; too often his therapeutic am-

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bition causes him to forget that there is such a thing as trying to do too much. The counselor's desire to make his mark is understandable, but he must examine his own unconscious motives so that his enthusiasm will not result in detriment to the patient.

When it comes to actual counseling theories, our approach is eclectic. We use Carl Rogers' non-directive counseling to a considerable degree, and find, as Rogers predicted,* that it is effective with psychotics. We do not hesitate, if the need arises, to have a friendly discussion with patients; to use persuasion, to give information and reassurance, to ask direct questions, and even at times to make use of criticism and disapproval. Criticism is always used cautiously, and directed toward behavior, not toward the individual.

APTITUDE AND ABILITY TESTS

Counselors participate with the department of psychology in a testing program which helps clients to discover their occupational aptitudes and abilities. One of the tests is the standard "Strong Vocational Interest Blank." Projective procedures, the responsibility of the psychology department, are sometimes given by student-counselors under the supervision of the psychologist.

Once a month, work-program supervisors and counselors meet to discuss their own problems and those affecting their personnel. The chief rehabilitation counselor moderates this meeting. His role is to weigh the dynamics of the information he receives, and to interpret, with the help of the work program coordinator, how this information can be used to promote the program's goals.

Our work program also includes a variety of extramural job-placement activities. We urge clients to inspect classified advertisements, and we arrange introductions for them to employers who are willing to hire persons who have been mentally ill. Occasionally, we encourage the client to consider returning to his pre-hospital employment. At other times, we suggest that he consult a public or private employment agency. When a client pays a fee to an agency he has more of an incentive to remain in a job, enduring difficult circumstances, until the fee has been repaid. By that time, he usually finds that he can tolerate his job problems after all.

JOB-SEEKING

There is one school of thought which assumes that an emotionally disturbed person must find his own job if he is to achieve occupational success; that help from his counselor will prolong his dependency and make his employer doubt his ability to act for himself.

We believe that a psychiatric patient's approach to vocational placement is determined largely by his personality resources. It is ideal when a client can seek his own job opportunities and arrange his own interviews. This ideal is one of the goals of vocational counseling, but we find that many clients who are able to work successfully are not able to make their own job-placement arrangements. In such cases, we make the arrangements, while continuing to encourage the client to do as much as he can for himself.

Finally, we have found that clients frequently are in great conflict over whether or not they should tell a prospective employer about their illness. We feel that this is not a question we can answer for them. Some clients who have an unconscious desire to remain unemployed besiege a prospective employer with detailed, dramatic accounts of their condition. These people, of course, require further counseling and work conditioning. We do believe that, generally, the applicant can present information about his disability in a simple, frank, and matter-of-fact manner. Often it is not necessary to inform the employer of an individual's past emotional condition. In any case, decisions of this sort depend upon individual circumstances.

Neither the present nor the forseeable future holds all of the answers to the problems encountered in our work-program and job-placement efforts. We are, however, firmly committed to our philosophy that we must make haste slowly, and that progress depends on our staff's recognition of fundamental human values upon which the successful rehabilitation of every convalescent mental patient depends. •

*Rogers, Carl R.: *Client-Centered Therapy*, Boston, Houghton Mifflin Co., 1951, p. 167.

Intramural Softball

THE 1960 GIRLS' SOFTBALL SEASON at Faribault (Minn.) State School and Hospital was successful on all counts. Eight teams of patients from seven buildings participated in the intramural program, assisted and encouraged by twenty student-volunteers from nearby Bethlehem Academy. Patient-players totaled 81 during the season, with two games being held simultaneously each Monday evening. The student-volunteers contributed approximately 235 hours to serving as team captains, umpires, score keepers, and extra players on the field.

The season concluded with an award night, when, in a switch from the usual order of such things, the patients were recognized for their outstanding work with volunteers. Every patient who had participated in the program at some time during the summer received an award. Those who had played in four or more games received a gold seal stamped "Rec"; those who had played in three or less games received a gold star for each game.

The awards were presented by the rehabilitation therapy supervisor in the presence of the student-volunteers and approximately 200 patients, who applauded each player heartily as she came up for her award. The evening concluded with refreshments and a community sing. Then the patients walked back to their various buildings with their friends, the volunteers. All were agreed they had shared a wonderful summer.

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A School for Emotionally Disturbed Children

By the Faculty of the Gaebler School,
Metropolitan State Hospital,
Waltham, Massachusetts

In 1945 the Massachusetts Legislature proposed that all children admitted to state mental hospitals should be accommodated in quarters separate from those of adult patients. Rather hastily, three wards of the medical building at the Metropolitan State Hospital in Waltham were prepared to house juveniles until the children's unit could be built. Plans for the unit included four classrooms, a gymnasium, and a library, the whole to be presided over by four teachers, a librarian, and a physical education instructor. This was the beginning of the Gaebler School, established to provide an education from grades one to eleven for resident child-patients.

ACCREDITED PROGRAM

Several years of trial and error were necessary before the school functioned successfully. Its purpose had to be defined; the line between therapy and education had to be drawn.

Administrators realized that an accredited school program was essential so that children could continue their education during confinement and be prepared to enter public schools at the conclusion of their treatment. High-school age patients especially need to earn credits that can be acceptably transferred to other secondary schools. Therefore, a curriculum based on those of local public school systems was drawn up, and standards for promotion were established. In 1956 the Massachusetts Department of Education evaluated the Gaebler School and certified it to transfer needed credits.

Children entering the unit go through an observation and evaluation period. If they are deemed capable of attending the school, the ward doctor places their names on its waiting list. This selective process establishes school attendance as a privilege in the eyes of the patients.

Classes start in September and differ very little from those in public schools except for the increased patience and understanding required of the teachers. The school day includes five periods of instruction between 8:30 a.m. and 3 p.m. No child spends more than two consecutive hours in academic study. Three periods are academic, one is devoted to physical education, and the other alternates between library study and occupational therapy, which takes the place of shop or home economics.

Each teacher has charge of at least three grades, although some are occasionally responsible for four because classes are open-ended to receive latecomers. When the number of entering pupils does not equal the number leaving, new pupils are absorbed by the nearest class to their own which has a vacancy. A teacher instructs from eight to twelve pupils a day, but never more than six at one time. This enables her to have a closer relationship with individual pupils and to control temperament clashes among them.

Discipline is a major problem in the school, since most of the children have been unaccustomed to either group or self-discipline prior to their confinement. In the beginning, leniency and permissiveness are necessary so that the children will not develop a complete emotional block when faced with the reality of a school from which they cannot easily run away. This is a delicate maneuver —to win the confidence and cooperation of would-be truants. They must be humored gently and given time to accept members of the staff as friends who are anxious to help them. A pupil whose conduct is unruly is returned to the ward. If he misbehaves frequently, the ward doctor has a talk with him.

A daily teachers' conference is held so that problems may be dealt with immediately. Twice a week the senior physician or a ward doctor attends the conference to lend his medical knowledge to teachers who are having difficulty in establishing rapport with specific children. Every Friday morning the teachers attend a hospital staff conference, which often helps them to see their work in proper perspective.

THE ELEMENTARY SCHOOL

Teachers regard the instruction of emotionally disturbed children at the primary level as one of their greatest challenges. Many of these children have been re-

jected repeatedly by parents, foster parents, school systems, and society in general. They need to feel that they are wanted, that they are secure in their surroundings and with their teacher and classmates. Social skills are almost completely lacking in beginning pupils. They all talk at once and will not cooperate with each other. They reach for objects impulsively and handle them carelessly. The instruction of such children sometimes frightens young, inexperienced teachers, but those who possess a good background of public-school teaching find it to be one of the most rewarding of educational endeavors.

The manner in which patients are initiated into Gaebler School's elementary grades is most important. The school setting is informal. Objects of interest—a bowl of goldfish, a dish of turtles, stuffed toys, color picture books, and games—are placed around the room to invite the children's attention. They feel that the school is a place where they can have fun. No one is going to say, "Don't do this," but is more apt to say something like, "Have you looked at the pretty spots on Timmy Turtle's tummy?"

The teacher greets each child with a personal remark, perhaps commenting favorably on his appearance, or asking about interesting things he may have done the day before. She helps him to feel comfortable in the schoolroom, realizing that he has known only the atmosphere of the ward and recreation room. She often gets him off to a good start by permitting him to choose what he would like to do first. Sometimes a newcomer is lured into participation by the other children's enthusiasm for an interesting project that the teacher was foresighted enough to leave unfinished on the previous day.

The well-planned and varied elementary curriculum is designed to foster good work habits. Each period includes both study and play in order to maintain the children's interest. Competiton is very keen among them, and they are quick to sense the teacher's reaction to certain problems in which they are involved. She gains their cooperation by discussing why reasonable limits have been established to control their behavior. She often lets them make their own rules for conduct, and overlooks minor infractions when they do not affect the other children adversely.

AUDIO-VISUAL AIDS

Teachers present fundamentals of academic subjects in a rather gay, carefree manner, but always with a definite goal in mind. They employ the best methods to impart the kind of knowledge that provides a basis for coping with the simpler demands of everyday life. Number combinations are taught during games such as playing store and making change, or by keeping scores, etc. Reading is made more interesting by relating the subject matter to the children's personal experiences.

Generally, the children at the Gaebler School come from low income families. Most of them have never handled anything except expendable materials and inexpensive toys, and they enjoy manipulative activities in the school. Many have never been to a zoo, a farm, or an airport, because their opportunities for excursions have been limited. They are particularly receptive to pictures of places and things they have never seen and to sounds they have never heard. Therefore, their teachers can use audio-visual aids to good advantage.

Since tape recorders are complicated and easily damaged, the children are not permitted to operate them, but the simpler filmstrip projector can be entrusted to well-prepared children. The first few filmstrip showings are handled by the teacher so that she can explain the equipment to the children. Later, she shows them how to operate the projector and handle the filmstrip. After several months of such training, she is able to assign pupils in turn to operate the projector while she conducts the lesson. When this plan has been tried successfully several times, the teacher helps the class to form itself into a committee and select a chairman, who then assumes the responsibility for assigning the pupil operators.

THE SECONDARY SCHOOL

In addition to providing good academic training, the Gaebler School's goal in secondary education is to help each child achieve sufficient emotional growth to function effectively. The pupils must learn to live in an evolving world, to face the conditions of life, and to adapt to modifications of situations in which they find themselves. To attain these ends, the curriculum must include well-chosen, meaningful learning experiences.

A variety of emotional blocks beset emotionally disturbed children. The egotistical, hostile child refuses to

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learn. He may be the "I hate my teacher and won't do anything for her" sort. If so, the teacher must make him realize by her interest in him that she is different from the hated adult figures in his world. Some blocking results from a child's unconscious fear that success may be devastating in some way. This kind of child must be assured constantly that he has support and is secure.

Each child receives a great deal of individual attention in the classroom. He welcomes this close relationship with his teacher because it does not threaten him; he does not have to give anything of himself, but gratefully receives the help of his teacher who attempts to see problems from the child's point of view.

The teacher constantly strives to stimulate an appetite for learning in her pupils. To achieve this she employs various approaches and methods which depend upon the potential of each child. When individual attention is essential for learning experiences to be positive, the teacher works independently with one child while the other class members work on an assigned lesson. More frequently, well-constructed grouping processes have facilitated the learning situation, particularly in presenting English, history, general science, and mathematics.

Many successful group discussions are motivated by the lecture type of presentation. At first, youngsters display shyness, and resist actual participation in classroom discussion. However, members of the group are constantly assured that they are all worthy; each child becomes more and more relaxed, and finally contributes freely to the discussions.

The secondary curriculum is a relatively fixed one, flexible only to the extent necessary to adjust to the pronounced individual differences that characterize emotionally disturbed children. Completion of the curriculum results in the child's mastery of subjects offered in any adequate secondary school; it is not only a requirement for full credit, but is also an achievement anticipated by the children themselves.

THE LIBRARY

For pupils of all ages, the school library is a place where they can expand their horizons and their knowledge still further. It actually functions as a combination study hall, reference center, and general room for reading. drawing, painting, and letter-writing. Instead of following a strict Dewey Decimal Classification, the library is organized in a modified "reader-interest" pattern. Some of the books are arranged on the shelves in categories, such as Animal Stories, Children of Other Lands, Sports, Fairy Tales, Family Stories, Easy Stories, Biography, Science, Westerns, Dolls, Indians, Boys' Stories, Girls' Stories, Reference, etc.

A librarian in this kind of school must develop ways to encourage the timid and reluctant. On the other hand, she often has difficulty in maintaining quiet in the library because some of the children are given to compulsive outbursts. Sometimes a group of only three or four will

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become very unruly, while on other occasions as many as ten children can be very quiet and work harmoniously at various projects.

VOLUNTEER FACULTY

By means of the facilities and methods described here, the Gaebler School is striving to educate and reclaim youngsters for useful lives. The faculty, like that in many other schools, is sometimes too small to meet the demands made upon it. This problem has been partially solved by the use of volunteer tutors—students who have completed their practice teaching, former teachers who are not working at their profession, or retired teachers—who serve the school from three hours a day to fifteen hours a week.

A Harvard doctoral candidate spends one day a week helping children to master reading difficulties. Four other Harvard graduate students do work in the school as a field project for a course in educational psychology. There is also a possibility that arrangements can be made to have Boston University students do their practice teaching in the school.

Because children must leave the unit when they are 16, the school can shepherd them only through grade 10. The more severely disturbed, who are incapable of continuing their studies in public schools, are transferred to the hospital's adult unit for additional treatment. Others who are ready to take their place in the community, but are not likely to progress in public schools, find jobs. Children who successfully complete the curriculum and do not require further treatment receive promotion cards and transfer to schools outside the hospital.

So far, a shortage of Gaebler School personnel has made it difficult to do follow-up studies on former pupils. However, arrangements are being made with the hospital's social service to conduct such studies. One, made by several faculty members, concerned a specific group of former Gaebler pupils who had been problems in public school before they were committed to the unit. It revealed that many of these children were working successfully at various jobs.

Parents' reports are the best index, at present, of how well pupils are getting along after transfer to other schools. These reports often include happy remarks about children who are receiving honor grades, and they are gratifying evidence of the Gaebler School's contribution to the rehabilitation of emotionally disturbed children. •

Special Diets Simplified

COOPERATION BETWEEN the medical, nursing, and food service staffs is one of the most important factors in efficiently ordering, preparing, and serving special diets. At Agnews State Hospital, San Jose, California, effective liaison makes it possible for a limited staff of only one cook, one assistant cook, one relief cook, and one food administrator to serve as many as 250 special diets.

Agnews' dietary program is based largely on a special diet manual, compiled by the California Department of Mental Hygiene food administrators and including such diets as ulcer regimen, bland ulcer, low residue, low cholesterol, post-gastric surgery routine, high protein, tube feeding and formula recipes, and house diets. Copies of the manual are available to physicians, nurses, and food technicians. The food staff prepares diabetic and reducing diets according to the food exchange plan of the American Diabetic Association, the American Medical Association, and the American Dietetics Association.

Physicians order from the diet manual according to the needs of their patients. Each special diet prescription contains the patient's name, ward, type of diet, and diagnosis; the date; and the physician's signature.

Prescriptions are sent to the food administrator, who makes up the food orders. She plans special diets with the general menu items in mind so that she can use the same foods for both whenever possible. This permits her to place one large order for fruits and vegetables included in both restricted and unrestricted menus, thus cutting down the number of small orders she would otherwise send to the farm and orchard. She orders meat, fish, vegetables, fruits, and staples a week in advance. She requests salt-free bread from the bakery when there is a need for it, and orders salt-free butter quarterly.

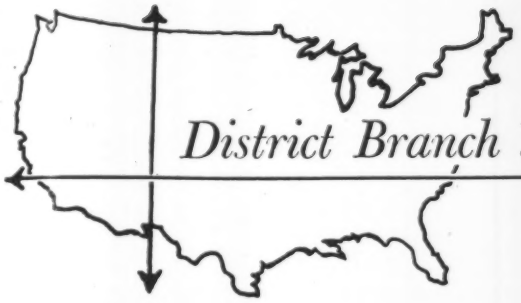
When the food administrator has made up the prescribed food orders, she forwards them to the diet kitchen, which is located in the central kitchen of the main food service building. The food is prepared here, and then stored in electrically heated food carts.

A motorized truck transports the carts to special diet areas designated by the medical, nursing, and food service staffs. At Agnews, special diet areas include eight medical and surgical floors, one annex in the receiving and treatment division, and twelve wards. Each ward dining room has stainless steel tables spaced so that the food cart, when properly placed, completes the serving line.

In serving the patients, daily menus for each type of diet are followed. Tags bearing the patients' name, ward, and diet are used to identify trays. Bedside trays are sent to the wards on tray-carts. Ambulatory patients eat cafeteria-style.

Food service assistants are in charge of the dining room, assemble and serve all the food, and handle housekeeping chores in dining areas. The inservice training program, required for all food service assistants, plays an important part in maintaining the efficiency and accuracy of the dietary program.

MARGARET M. BALL,
Food Administrator



District Branch News

The response of the district branches to Dr. Saunders' request in the January issue of MENTAL HOSPITALS *has been gratifying. Newsletters from various parts of the country are beginning to reach the editorial staff, but many are still among the missing. Your cooperation in sending us news of district branch and mental hospital collaborative efforts in your area will be appreciated.*

MICHIGAN—*Service to State Institutions*

Eugene J. Alexander, M.D., president of the Michigan Society of Neurology and Psychiatry, and head of the district branch, has written to all state institutions in Michigan to inquire in what ways members of the society might be of service to them. So far he has received a number of requests for speakers.

KANSAS—*Local Society Participation*

The Kansas District Branch is urging its members to become more active in the local medical societies by submitting articles for publication in the Kansas Medical Society Journal, attending and presenting papers at meetings of local medical societies, giving lectures to general practitioners, and releasing press notices of actions of KDB committees affecting other groups of physicians.

NEY YORK—*Postgraduate Training*

In New York, in response to the growing demand from physicians in general medicine and other specialties for psychiatric education and information, a program of postgraduate training is being organized by the Department of Mental Hygiene, the New York State Academy of General Practice, and New York State district branches, with the cooperation of the State Medical Society.

The Department of Mental Hygiene will provide staff assistance and financial aid, and will offer the resources of the state hospitals to the local planning committee. Directors of community mental health services also have been urged to take part in the programs.

The courses, as planned at this time, will be similar to the seminars and one-day sessions conducted at the various state institutions in the past, and will include such topics as "Management of Psychiatric Emergencies," "The Use of Drugs," "After-Discharge Care of Mental Patients," and other applications of psychiatry to general medical practices.

WISCONSIN—*Relations with Psychologists*

The Wisconsin Psychiatric Association is offering psychologists the services of an interprofessional group from the district branch for consultation in matters affecting the two professions in legal, ethical, and controversial areas.

COLORADO—*Mental Health Center*

Colorado is working fast at realizing the master plan for mental health presented by Franklin G. Ebaugh, M.D., president of the Colorado District Branch (MENT. HOSP. 12:23-24 [Jan.] 1961). Construction of the Fort Logan Mental Health Center, a part of the state system, began in February and will be completed by the end of the year. This institution will be closely integrated with local mental health clinics, which will refer patients in need of hospitalization and provide after care and follow-up-services. The center's staff will offer intensive treatment to patients and provide the clinics with professional resources. Training and research programs at the center are also planned for the future.

CALIFORNIA—*Higher Salaries*

Members of the Southern California Psychiatric Society were recently told that one of the greatest problems of the Department of Mental Hygiene is related to the employment of satisfactory personnel and their maintenance in the state's mental institutions under the current pay schedule. This condition is particularly acute with "treatment staff," i.e., psychiatric technicians, graduate nurses, social workers, clinical psychologists, and physicians, whose salaries are not comparable to those they may obtain in general employment. Daniel Blain, M.D., director of the department, pointed out the close relationship between standards of care and the caliber of personnel hired. Rapid turnover in personnel vitiates the good effects of inservice training programs and the resulting benefits to patients. After hearing of this report, the participants decided that the three California district branches (Southern, Central, and Northern) would write a joint letter to the governor outlining the situation and urging the inclusion of increases in his budget proposals.

—*And Private Psychiatric Resources*

At the same meeting, Dr. Blain emphasized the need for long-term planning for an over-all approach to the problem of mental illness. He stressed his desire to have private psychiatric resources carry at least 50 per cent of the treatment programs throughout the state, and recommended that many state operations be taken over by community groups.

REVIEWS & COMMENTARY

READERS' FORUM

Rural Sheltered Workshops

Our hospital has recently started a sheltered workshop for patients who are not yet ready to leave, but who need evaluation in an actual work situation and to earn some money prior to job placement outside the hospital.

So far we have contracts with various bottling companies 25 to 30 miles away to repair the wooden cases for their soft drinks, and we have done some mailing of advertising material for such companies as Sears Roebuck and Company. The main problem we have encountered is one of transportation because of distances involved. Otherwise, our experience to date has been encouraging.

As far as we know, this is an experimental project for a rural hospital. However, there may be others who are attempting similar programs. If so, we would very much appreciate any material dealing with their experiences, problems, and solutions of problems in this type of project.

ALFRED K. BAUR, M.D.
Superintendent
State Hospital No. 1
Fulton, Missouri

Note: The staff of MENTAL HOSPITALS *would appreciate receiving copies of any material sent to Dr. Baur in response to this letter.*

The Deadliness of Uniformity

May I congratulate you on your editorial in the January issue of MENTAL HOSPITALS. I certainly agree that this patient's letter was well worth publishing. One might, of course, make many comments on it, but to me the most important sentences are "Room and board and diversions have improved but the alleviation of human misery, particularly of mind, heart, and spirit, shows no appreciable gains. Daily environment and routine after a year causes each day to seem the same, regardless of any diversions." Of course, the former sentence is an indictment of our failure therapeutically, and, while this is of basic importance and requires renewed vigor in attacking the problem, I feel that there is in these statements an indictment of another kind.

During the past decade or more there has been a great awakening to the need for humanizing the environment of the long-stay mental hospital patient. Many many techniques for employing, diverting and encouraging these patients have been devised, reported, and advocated. All seem to have had good immediate success and while many undoubtedly have died an early death, others have been incorporated into the ongoing routine of the hospital. I do not seem to have seen reports of the results at this later stage when the operation has become routine. If these schemes are as effective as we like to think, this kind of a letter could hardly be written by a patient from an old and respected mental hospital (which presumably has incorporated some of these programs).

Does the second sentence—"Daily environment and routine after a year causes each day to seem the same regardless of any diversions"—give us a clue? Does this not remind us of the deadliness to the individual of too much routine, conformity, and control? As psychiatrists we preach the fact of individuality and the need to tailor our therapy to the needs of the individual. Even in our big hospitals we try to individualize our formal therapeutic activities, yet at the very same time the basic human needs of daily life are provided only in uniformity. Of course, this is largely true of general hospitals too, but whether in general or mental hospitals the important thing is how long the patient has to remain there. Short periods of a few weeks or several months can be borne without difficulty, but for longer ones and especially where the patient must remain uncertain of the duration, it becomes a matter of fundamental importance.

How can we possibly satisfy such a need? Obviously only by allowing sufficient freedom of choice in the basic activities of eating, sleeping, clothing, recreation, etc., so that each patient can develop his own pattern of living again.

Is this more revolutionary than open doors? I fear it will seem so to many. Hospital staff members display their need to exercise control over their patients, and their resentment of any deviation from the "normal" pattern. The patient who does deviate is liable to be labeled a trouble maker, attention seeker, or worse. In casual talk, doctors often hint that nurses are especially prone to this kind of response. But is it any more true of them than of us? Do not we too tend to blame the patient when our scheme of treatment does not work, or the patient rejects it as something he does not want?

Since freedom to arrange the details of personal living should not directly affect relations with the community—thus contrasting with open-door policies—it should logically be easier to introduce, but I fancy that we will, in fact, find it to be much more difficult to achieve.

These reflections have been stimulated by your editorial and I wish I could conclude by setting out an outline of how to do it. Unfortunately, the organizational and administrative changes necessary to do a thoroughgoing job in these times are not simple except in theory. But a little thought suggests that some individuals in our hospitals have some natural insight into these problems

and instinctively try in many minor ways to offset the dead hand of routine large-scale organization.

Recognition of the value of this attitude and an understanding of the important principle involved could, perhaps, allow the revolution to take place piecemeal wherever possible, and then be gradually expanded by alteration of the more fixed rules.

I set out to say a word of thanks for your editorial, but my remarks seem to be more voluminous than I had intended. Perhaps this in itself is testimony to the value of the piece.

W. W. BLACK, M.B., Ch.B.
Clinical Director
The Provincial Hospital
Lancaster, N. B., Canada

FILM REVIEWS

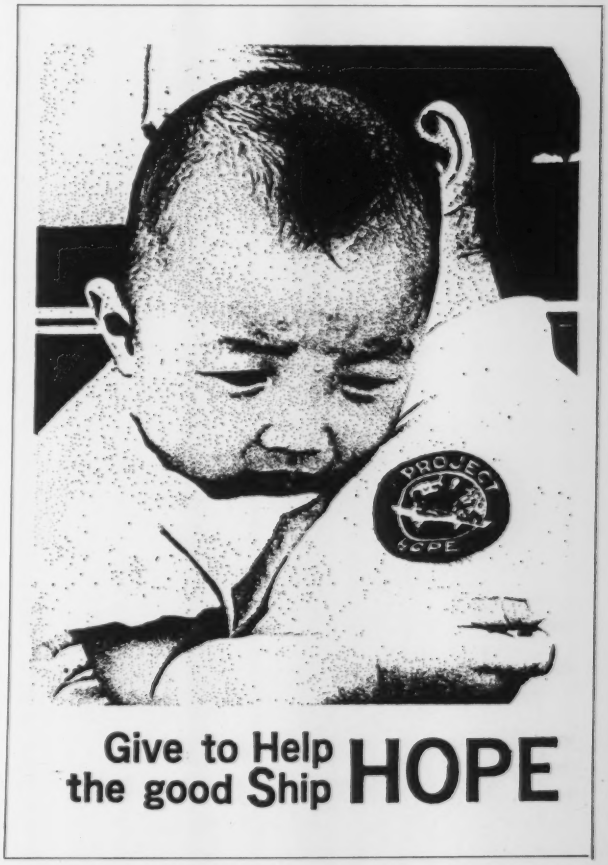
The use of real patients instead of actors in educational films about mental illness unquestionably gives a stamp of authenticity to these films—especially in psychiatric interviewing scenes. Robert Anderson, the Canadian film director responsible for the effective use of this technique in "The Faces of Depression," has produced four new films based on psychiatric case histories. H. E. Lehmann, M.D., clinical director of the Verdun Protestant Hospital in Montreal, served as consultant for all four films. None are dramatizations; the patients themselves tell their stories and their doctors comment on the psychological factors. Originally shown to the general public over Canadian television in 1960, these 16mm. films have just been made available in the United States under the comprehensive title of "The Disordered Mind." Because the high caliber and undoubted usefulness of the films qualify them for more than a cursory review, only two in the series will be reviewed this month. Reviews for the remaining two films will appear in the May issue.

A CORONARY (black and white, 30 minutes) Produced by Robert Anderson Associates, Ltd.

What causes a coronary? Since more than half the deaths in this country are caused by conditions of the heart and arteries, it is safe to say that quite a few people are keenly interested in the answer to that question. In this film about the heart attack of a successful 34-year-old insurance salesman, the point is made that the patient's inner tensions and conflicts were important factors in his coronary. Mr. Anderson (who acts as a sort of interviewer-moderator in all of these films) discusses the patient's attack with the patient himself and with a heart specialist, Dr. Harold N. Segall. In detail, the patient describes what he felt before and during his heart attack. Dr. Segall reminds the patient of significant omissions in his story, revealing that—to this man—heart condition was inadmissable. Further light is thrown upon the patient's personality and its possible relation to his attack by his psychiatrist, Dr. Henry Kravitz, who gets the patient to describe himself as "an ambitious man," working hard to give his family financial security, trying always to be "first." At home, or while visiting in-laws, he sometimes feels restless ("I gotta get out") and notices a feeling of tightness in his chest when he is thwarted in his attempts. Another psychiatrist, Dr. Nathan B. Epstein, comments on the wide range of psychosomatic illnesses and makes the point that the way in which we handle problems of everyday living is often the decisive factor in causing illness. At the end of the film, the patient states that he has been learning new patterns of living which he hopes will cut down the possibility of another attack.

A DEPRESSION (black and white, 30 minutes)

This case is somewhat more spectacular than the first in that it involves a man who attempted to murder his wife and child and then take his own life. Mr. Anderson reconstructs the case by interviewing the police officer who had been called to the scene, and Dr. Breen Marien, the operating surgeon who treated the patient's self-inflicted wounds. A few days later, the patient is shown being interviewed by a psychiatrist, Dr. H. B. Durost. The patient is suffering from a severe depression, is unable to believe that his wife and child are not



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hostility,
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hyperactivity
reduces confusion,
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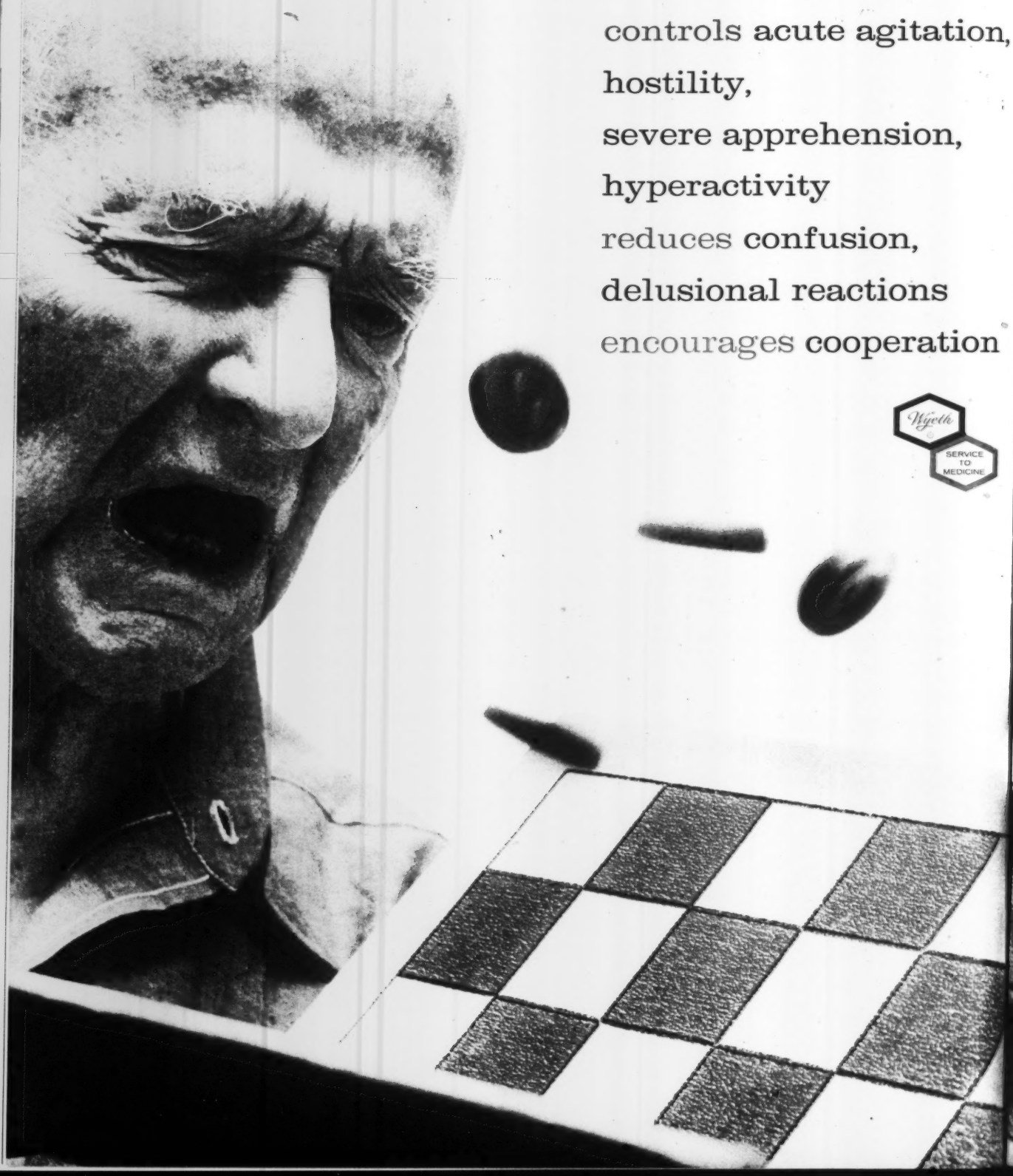

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For further information on prescribing and administering SPARINE, *see descriptive literature, available on request.*

dead, and feels that "everything is over." Mr. Anderson then discusses prognosis and treatment with Dr. Durost, who believes that drug therapy and ECT should help this patient. A few weeks later, after psychiatric treatment, the patient is filmed again and the change in his condition is remarkable. Eight months later, the patient is back at work, although he continues treatment at an aftercare clinic. He and his wife discuss frankly the business of rebuilding their lives after the near-tragic attempted murders and suicide. The patient believes that he will recognize any symptoms of his illness should they reappear in the future, and will seek psychiatric help in time.

In both of these films, the interviewing is so skillfully handled that the audience gets an enlightening picture of the cases under discussion and what can be done for people who suffer from these illnesses. There is nothing morbid or sensational in the presentation of the cases; emphasis throughout is on the positive side. But Mr. Anderson and his psychiatric associates are not trying to "sell" the audience on mental health. They present, in true documentary style, unrehearsed conversations with the patients, before and after treatment. These are interspersed with calm, reassuring, almost matter-of-fact explanations by the doctors. The net result is a series of sensitive films that will be very useful in educational programs with the general public. They will also be valuable teaching aids for all students of medicine, nursing, and social work. For purchase information, write to International Film Bureau, 332 South Michigan Avenue, Chicago 4, Illinois.

JACK NEHER
Mental Health Materials Center

BOOK REVIEWS

CREATIVE VARIATIONS IN THE PROJECTIVE TECHNIQUES—by Molly Harrower, Ph.D.; Pauline Vorhaus, Ed.D.; Melvin Roman, Ph.D.; and Gerald Bauman, Ph.D., Springfield, Ill., Charles C Thomas, 1960, viii + 138 pages, $8.50.

This book presents three contributions each marked by a twist of creativeness in the use of familiar procedures in psychological assessment. Molly Harrower, editor of the series, introduces and illustrates the judicious use of confronting carefully selected patients with their own test results, with the aim of promoting insight.

Calling the procedure "projective counseling—a psychotherapeutic technique," she demonstrates its use with one patient, with a group of patients, and with a husband and wife. The possibility of using test materials directly with patients has awaited just such an exposition.

Psychological assessment has proven possibilities of revealing both surface and deeper aspects of personality functioning. If, in addition, self-confrontation is a maturing experience, then the rationale of helping the patient to see himself is obvious.

Possible hazards of this procedure are apparent to Dr. Harrower who raises and cogently answers the first questions one might ask about this innovation. Dr. Harrower's "creative variation" set down in 38 pages merits exploratory trials in hospital practice as well as counseling practice.

There is in this technique an opportunity and a challenge to test whether sharing our insights and understanding more directly with hospitalized patients will help them "come to grips with themselves."

Pauline Vorhaus' 52-page piece, "the structured interview technique," is a carefully detailed manual of a procedure synthesizing the task of drawing a person with an elaborate structured interview. The patient is first asked to draw a person of his own sex; then to fill out an elaborate interview form as if speaking for the person he has drawn; and, finally, to fill out the form for himself. The projected life and the patient's own life are then compared in detail.

For research into developmental problems of personality, the thoroughness of this technique in covering life histories commends it.

A case presented at length demonstrates that this approach brings into focus the material obtained by other testing procedures and interviews.

For routine hospital use this process seems so time-consuming as to limit its value. However, shorter, more serviceable versions are easily abstracted from the carefully structured interview-form which, taken at length, makes a contribution to the methodology of studying the single case.

The joint contribution of Melvin Roman and Gerald Bauman on "Interaction Testing" is subtitled "A Technique for Psychological Evaluation of Small Groups." In 43 pages they illustrate its application to two marriages, an engaged couple, a mother with a schizophrenic son, a stable homosexual relationship, and a group-therapy situation.

The procedure is as simple as administering familiar brightness and projective tests to pairs of members of groups separately, then readministering with the requirement that the pair or group produce a collaborative response. The process of arriving at responses is reported along with the results, which are scored according to established procedures. Comparisons are made between solitary and collaborative productions, the critical point being whether the joint production is different from and/or better than the individual productions.

The need for techniques of psychological assessment of interacting people is urgent. This social adaptation of tests of individual psychology is a creative variation. Yet, judging from some case material presented, the evaluation of responses and the meaning of scores apparently become an even more vexing problem in this procedure than in current testing. The proposed variant warrants much exploratory work.

In summary, the book is well named and a credit to all concerned, as Bruno Klopfer, Ph.D., suggests in a brief foreword.

JOHN ARSENIAN, Ph.D.

USE OF GROUPS IN THE PSYCHIATRIC SETTING: Proceedings of the Workshop Conference Sponsored by the National Association of Social Workers in Cooperation with the Continuing Education Service and the School of Social Work, Michigan State University, East Lansing, 1958.—By Robert Chin; Grace L. Coyle; Raymond Fisher; Rebecca Glassman; Frances P. Guzie; Hyman S. Lippman; Leon Lucas; Marion B. Sloan; John H. Wax; Gertrude Wilson, New York, National Association of Social Workers, 1960, 150 pages.

This is a condensed report of the papers and discussions at the Workshop Conference on Group Process in the Psychiatric Setting held in June 1958 at the Kellogg Center for Continuing Education, East Lansing, Michigan. The stated purpose of the conference was to bring together social caseworkers and group workers who were leading groups in mental hospitals and clinics, and to publish their deliberations for others entering the field.

As early as 1909, the report points out, social workers had begun experimenting in group work for the mentally ill. This was at Hull House and involved young drug addicts and housing groups for the mentally ill. By 1936, group work was a recognized subdivision of social work, and ten years later the American Association of Group Workers came into being. An increasing number of social-work schools now offer special group-work training.

Much of the report is devoted to questions of the differences and similarities in methods of operation between caseworkers and group workers, and the special knowledge which group leaders need to have. The report also includes accounts of groups of patients in a VA mental hospital and their relatives, a discharged patients' club, and activity therapy groups for children in the latency period. Criteria for group membership are discussed and there is a review of the literature on the subject of groups.

The advantages of group therapy are vigorously defended but the writers have a hard time documenting their subjective impressions or even formulating how group therapy should be accomplished. There are several outlines suggested for evaluating groups, with a description of the phases of development, and many pleas for further research. Qualifications for leadership and the leader's role are explored, and there is a glimpse of the typical content of group discussions.

As the authors are aware, they raise almost as many questions as they answer, but the report should incite more constructive thinking in a relatively new field and help the beginner avoid pitfalls through the knowledge of the experience of others. This booklet should prove useful reading for any social worker engaged in group work or contemplating starting a group in a psychiatric setting.

MARY B. PALMER
Psychiatric Social Work Supervisor
Beth Israel Hospital, Boston, Mass.

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Containing 100 mg. of purified, water-soluble chlorophyll derivatives (as standardized in *Tests and Standards for New and Nonofficial Remedies*), DERIFIL Tablets provide up to twenty times the activity of previously available chlorophyllin tablets. One DERIFIL Tablet daily normally provides effective odor control, though much higher dosages may be administered with complete safety, if desired.

Supplied in bottles of 30 and 100, and in jars of 1000.

Samples and literature available on request.

1. Morrison, J. E.: Hospitals *33*:97 (July 16) 1959.
2. Laitner, W.: Psychiat. Quart. Suppl. II *29*:190, 1955.

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NEWS & NOTES

Quarterly Calendar

A.P.A. ANNUAL MEETINGS

1961 May 8-12, Morrison Hotel, Chicago, Ill. (117th)
1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

A.P.A. MENTAL HOSPITAL INSTITUTES

1961 Oct. 16-19, Sheraton-Fontenelle Hotel, Omaha, Neb. (13th)
1962 Sept. 25-27, Americana Hotel, Miami Beach, Fla. (14th)
1963 Sept. 23-26, Hotel Sheraton-Gibson, Cincinnati, Ohio (15th)
1964 Sept. 28-Oct. 1, Hotel America, Boston, Mass. (16th)

OTHER PROFESSIONAL MEETINGS

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, Annual Meeting, *April 13-16*, Hotel Berkeley-Carteret, Asbury Park, N. J.

AMERICAN ACADEMY OF GENERAL PRACTICE, Annual Scientific Assembly, *April 17-20*, Miami Beach Auditorium, Miami Beach, Fla.

SOCIETY OF MEDICAL PSYCHOANALYSTS, Academic Lecture, *April 19*, Medical College, New York City.

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOANALYSIS, Annual Meeting, *April 26*, Karen Horney Clinic Bldg., New York City.

AMERICAN PSYCHOSOMATIC SOCIETY, Annual Meeting, *April 28-30*, Atlantic City, N. J.

MENTAL HEALTH WEEK, *April 30-May 6*.

NATIONAL GERIATRICS SOCIETY, Annual Convention, *May 1-4*, St. Francis Hotel, San Francisco, Cal.

AMERICAN ASSOCIATION ON MENTAL DEFICIENCY, Annual Meeting, *May 2-6*, The Netherland Hilton, Cincinnati, Ohio.

AMERICAN PSYCHOANALYTIC ASSOCIATION, Annual Meeting, *May 5-8*, Palmer House, Chicago, Ill.

ACADEMY OF PSYCHOANALYSIS, Annual Meeting, *May 6-7*, La Salle Hotel, Chicago, Ill.

ACADEMY OF GROUP PSYCHOTHERAPY & PSYCHODRAMA, Annual Meeting, *May 7*, Morrison Hotel, Chicago, Ill.

AMERICAN ACADEMY OF CHILD PSYCHIATRY, Annual Meeting, *May 7*, Palmer House, Chicago, Ill.

AMERICAN SOCIETY OF MEDICAL PSYCHIATRY, Annual Scientific Session, *May 7*, Morrison Hotel, Chicago, Ill.

COUNCIL OF STATE GOVERNMENTS—Interstate Compact on Mental Health, *May 7*, Morrison Hotel, Chicago, Ill.

ASSOCIATION OF MENTAL HOSPITAL CHAPLAINS, Annual Meeting, *May 8-12*, Sheraton Hotel, Chicago, Ill.

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, Annual Meeting, *May 12*, Morrison Hotel, Chicago, Ill.

CANADIAN PSYCHIATRIC ASSOCIATION, Annual Meeting, *June 4-10*, Queen Elizabeth Hotel, Montreal.

WORLD CONGRESS OF PSYCHIATRY, *June 4-10*, Queen Elizabeth Hotel, Montreal, (Inq. Allan Memorial Institute, 1025 Pine Ave. West, Montreal 2, P.Q.)

SOCIETY OF BIOLOGICAL PSYCHIATRY, Annual Convention & Scientific Program, *June 9-11*, Claridge Hotel, Atlantic Ctiy, N. J.

AMERICAN GERIATRICS SOCIETY, Annual Meeting, *June 22-23*, The Waldorf-Astoria, New York City, (Inq. Dr. R. J. Kramer, Sec., 2907 Post Rd., Warwick, R.I.)

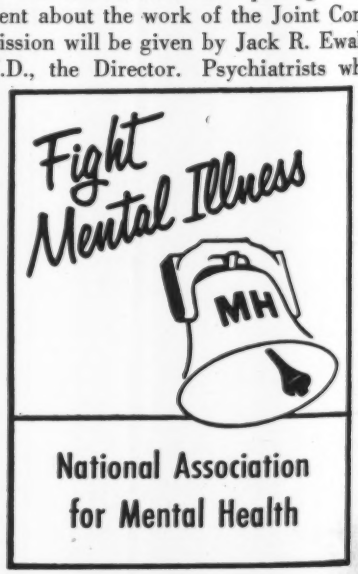
AMERICAN MEDICAL ASSOCIATION, Annual Meeting, *June 26-30*, New York City.

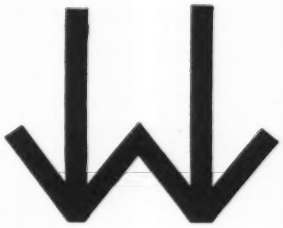
Institute Topics Announced

Registrants at the 13th Mental Hospital Institute will discuss the report of the Joint Commission on Mental Illness and Health under ten major headings, which the Program Committee has extrapolated after careful study and conference. The ten headings fall into three major groups, Group A: nonmedical care; aftercare; intermediate care, and rehabilitation; public information; research. Group B: Emergency service and secondary prevention; psychiatric units in general hospitals; mental health clinics and private patient care. Group C: Major mental illnesses, including those of children and offenders; care of chronic patients, including seniles; private psychiatric hospitals and intensive treatment centers.

The number of participants and the amount of time scheduled for the different topics will vary according to the scope and importance of the subject matter in the context of *Action for Mental Health*, the title under which the report has been published by Basic Books Inc. of New York. On Page 11 of this issue is the first of a series of articles on the report.

At the Institute an opening statement about the work of the Joint Commission will be given by Jack R. Ewalt, M.D., the Director. Psychiatrists who





How the Airkem Program gets to the heart of the problem of Environmental Health in Hospitals

There's no mystery about it. The Airkem Program does all the jobs that have to be done. It cleans all surfaces. It disinfects – reduces cross-infection. It kills insects – every kind. And it counteracts odors, even the most obnoxious ones, without adding heavy perfumes or chemical smells. And all this while actually cutting down the work-load of your maintenance staff, since Airkem combines two or even three functions in one housekeeping operation!

This is the only complete program of basic hospital sanitation maintenance. Procedures are simple—all you do is insist that the indicated Airkem products are used in their proper places in the hospital.

Airkem matches a treatment to each air space, each odor problem, each sanitation maintenance task – walls and floors, rest rooms, laboratories, kitchens – wards, operating rooms, corridors, elevators – and produces a clean, odorless, agreeable and healthful environment for patients, visitors and staff. Inquire!

See opposite column for one specific Airkem benefit ▶

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have not been involved in the work of the Commission have been requested to give critical summations of the discussions on the last morning in plenary session.

In addition to the main theme, the Program Committee is planning the usual simultaneous sessions, an Academic Lecture, and a presidential address by Walter Barton, M.D. The panel, on the final afternoon of the Institute, has as its subject "Federal-State Relations—Formulae for Sharing Costs."

The Chairman of the Program Committee for the 13th Mental Hospital Institute is Alfred H. Stanton, M.D., Mass. Assisting him are James E. Gilbert, M.D., S. Dakota; John P. Lambert, M.D., N. Y.; John J. Blasko, M.D., Washington, D. C., and Mr. Joseph Greco, Mo.

PEOPLE & PLACES

HERE & THERE: **Dr. Willis H. Bower** has been appointed superintendent of Colorado State Hospital, Pueblo. He succeeds **Dr. F. H. Zimmerman** who retired. Until recently, Dr. Bower was assistant superintendent of McLean Hospital, Belmont, Mass.

Dr. David C. Gaede, former inspector of the A.P.A. Central Inspection Board, has moved to the West Coast where he now heads the Bureau of Private Institutions for the California Department of Mental Hygiene.

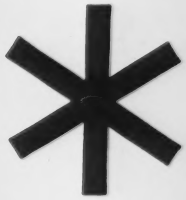
Sister Jean Marie of Sacred Heart Hospital, Yankton, South Dak., has been named chairman of the Council on Psychiatric and Mental Health Nursing, National League for Nursing.

Mr. Joseph R. Brown, executive director of the Indiana Association for Mental Health, has been elected president of the Mental Health Association Staff Council, an organization of individuals employed in professional capacities by mental health affiliates.

Dr. Seymour L. Pollack, formerly at Louisiana State University, recently became assistant superintendent of Galesburg State Research Hospital, Illinois.

Dr. George S. Stevenson, a past-president of the A.P.A., who is now vice-president of the World Federation for Mental Health, will become its president at the next International Congress to be held Aug. 30-Sept. 5, in Paris.

On May 1, **Mr. Philip E. Ryan** will become executive director of the National Association for Mental Health. Mr. Ryan is presently executive director of the National Health Council.



Airkem Helps Fight Cross Infection!

Infections committees in many leading hospitals are adopting Airkem techniques in their continuing fight against "staph" and other infections. They find the Airkem method helps effectively.

HOW?

Airkem attacks the essence of the problem –by halting, minimizing or preventing the spread of bacteria, fungi, protozoa. Cleaning and disinfecting are combined in every daily sanitation maintenance task, yet without adding to work-load of maintenance personnel. At point of contamination, suspected or unsuspected, Airkem methods set up a routine barrier. Each cleaning task becomes a microorganism-killing treatment – for walls, floors, rest rooms, laboratories, bedpans, urinals, surgical waste receptacles, diaper cans, garbage cans, everything. Cross-infection cannot "cross" without a crossing-place!

John Hulse, Airkem, Inc. Dept. MH-4
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Send representative to make FREE survey of our sanitation maintenance practice and demonstrate Airkem procedure for cross-infection control.

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